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Teenagers Discuss Drug Use

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children

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Two adolescents of the seventies—their major task to synthesize the developmental accomplishments of their past with their personal qualities, social ideals, and the opportunities available to them. What they will become, as one article (p. 213) in this issue suggests, is influenced by what their "environment has permitted and now permits and encourages" and their "own talents, needs, and defenses." The lead article gives us some adolescents' views of one confusing aspect of their environment—the use of drugs.

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"I think more people (adults) need to know just how teenagers think of drugs and why they take them."

In this response to a question from the Children's Bureau, a high school student unwittingly expressed the Bureau's own reason for making drug use the subject of the second inquiry to its 415 Youth Reporters. These reporters—all high school students preparing for college—had been selected at random from metropolitan areas in the North, South, Midwest and West, in both central city and suburban high schools. Early in January 1970 the Children's Bureau sent them four questions:

How do teenagers feel about the use of the various kinds of drugs by people their age? Do they feel differently about different kinds?

What makes some teenagers use such drugs?

What keeps some teenagers from using them?

Should adults take steps to discourage the use of drugs by teenagers and/or older people? If so, which adults should take steps and what steps are advisable?

As with its first Youth Report, on the generation gap,[1, 2] the Bureau's intent in soliciting letters from high school students was to find the main patterning of opinions among such young people, rather than to obtain an exact count. As the questions indicate, the Children's Bureau was concerned with attitudes rather than with the extent of drug use. It wanted to learn what young people think about the use and users of various kinds of narcotics and what they think ought to be done about the drug problem.

Replies were received from 205 students in 55 schools in 12 cities—a return of nearly 50 percent. This is a lower response rate than in the preceding inquiry, but nevertheless an unusually high one for a mail interview.

About one-fifth of the correspondents discussed the questions with friends or classmates before sending in their answers. One sent in the results of a questionnaire answered by 435 students.

DRUG USE AMONG THE YOUNG

AS TEENAGERS SEE IT

The young people's reports show some points of strong consensus, some points on which opinions divide rather evenly, and some on which a dissenting minority is substantial. Moreover, each group of opinions embraces a wide array of shadings and angles.

A detailed description of the inquiry and its results is being published by the Office of Child Development as the second in its series of *Youth Reports.*[3] Here we will present only an outline of the general patterns of response, along with some illustrative excerpts.

How much they know

Although the questions were not designed to measure how much the Youth Reporters know about drugs, their reports show that at least half the correspondents do know something about them—ranging from detailed information through recognition that differences in drugs exist, to a general separation of marijuana, or "pot," from all other drugs. More than a fourth lump all drugs together as bad.

I'm not against marijuana at all depending on the person and his surroundings. Speed (methedrine, dexedrine, benzedrine, etc.) and amphetamines are very dangerous and I'm down on them . . . . I'm down on all cheap trips and highs caused by taking large doses of household drugs or by inhaling products with a freon or methane base. They're extremely dangerous and unreliable. STP (a very potent hallucinogen) is also dangerous . . . . I think use of psilocybin, peyote, and its derivative mescaline, are okay and better than LSD because they come from natural sources . . . . LSD *in its pure form* can be a beautiful drug . . . . Heroin, morphine, opium, and cocaine are fantastic, but unfortunately addicting, so I can't condone their use.

A few reporters maintain emphatically that young people are very well informed, but others insist otherwise.

. . . We are taught in school, on T.V., at home, in books and magazines, and by friends about drugs. We know what will do what and what won't. When somebody uses a drug, the odds are he knows exactly what he's doing.

. . . But last is the dreaded confusion caused by contradiction in the reports of what drugs cause. Some say it is nothing, others say it kills, some say it helps one see differently, others say it destroys the mind. There is no one to believe and no one to turn to to gain the real truth. . . .

Pot and addiction. Opinions differ as to whether marijuana is or is not addictive, although only about half the correspondents comment at all on this point. About one fourth apparently think marijuana leads to addiction, either physically or psychologically. They say, for example, that it "leads to easy access to other drugs," that it may cause a person to feel "brave" enough to try something stronger, that "they like the high and want to get higher."

Some teenagers say, "Just once or twice and I won't get hooked." This usually isn't true. . . .

About one in eight, on the other hand, says that marijuana does not lead to addiction or to use of other drugs. "Kids are smart enough not to get hooked usually . . . ."

Nearly half of the correspondents give evidence in their reports that they have acquaintances who use drugs at least occasionally. Only ten directly state that they do not know any users. As many as one in seven say they know drugs are in their school, while only two state explicitly that their schools have no drug usage.

In a class discussion today everyone agreed that they knew at least one person who had experienced the use of a drug or was a habitual user.

Although the percent of kids who do use drugs is not

unusually large, the percent of kids who would absolutely refuse to take drugs is very small.

A few correspondents point out that many young people try marijuana or a "harder" drug only once or twice, to see what it's like. About a fourth explicitly disclaim using any kind of drugs themselves. Less than a tenth say or imply that they do use marijuana and only two that they use other drugs.

I personally have tried pot but I know I wouldn't want to continue on it. I think many experiment with drugs but the few who stay with it stay on it for a reason.

Attitudes toward drugs

Almost half the correspondents accept the use of pot, but within this half, four out of five explicitly reject the use of harder drugs. On the other hand nearly two-fifths of the correspondents express disapproval of all types of drugs. Only two reflect approval of "hard drugs," but about one in 20 reflect a tolerant attitude toward some other drugs, usually the amphetamines. A few call LSD and heroin "suicidal." "Pep pills," "pot," "hash," and barbiturates, when mentioned, are more generally viewed as safe.

Most don't have any qualms about tranquilizers, alcohol, Contac, aspirin, muscle relaxers, etc. As for drugs which are not in the mainstream of adult life, opinions are varied—marijuana is fairly accepted, whereas pep pills, acid, and narcotics are controversial.

Attitudes toward drug users resemble attitudes toward drug use. Those correspondents who express disapproval of all drugs report that drug users are considered "stupid," "crazy," "dangerous," "disgusting," "irresponsible." Some also say that drug users are rejected socially.

. . . The majority of teenagers today look down on drug users. They feel that drug users have no character or ambition, are not mature enough to handle the problems of life. They are a menace to society . . .

A larger proportion (more than three out of five) report mixed opinions, often because use of hard drugs is rejected, while the use of pot is regarded as "no worse than liquor" and "not as harmful as tobacco." Sometimes the reporters describe varying attitudes among the persons they know.

Ironically, there is a tendency to degrade a pot smoker and to feel sorry for the hard drug addict.

The varying shades of acceptance range from indifference to accepting without condoning. "It's their own life;" "a person has a right to wreck his own life if he wants to."

We believe we have witnessed, read, and felt enough about drugs to be able to say whether we can use or not use them . . . In general we say if a person wants to take drugs, let him and stop him only when it affects others.

Over one-fourth of the correspondents express some variation of this laissez-faire theme. About half as many say that drug users are accepted and even admired by some young people, who consider them brave, superior, "hip," "out of sight."

. . . In the midst of a group discussing their hallucinatory experiences, a nonuser feels positively left out.

A smaller proportion speak of compassion and pity for those who are "hooked." "It's really sad—you can see tombstones in their eyes."

Reasons for drug use

Almost everyone who answered the questions at all had something to say about why teenagers use drugs, and nine out of ten commented on why some teenagers do not. Often the reasons for use and for nonuse represent two sides of the same coin.

Some of the reasons given could be described as "positive" in the sense that they represent something desired or approved, and some as "negative" in the sense that they represent something to be avoided or resisted, or lack of an approved attribute. A few are "neutral," in the sense that they merely describe a situation.

"Negative" reasons for drug use. Leading all reasons, "positive" or "negative," reported for using drugs is the *impulse to escape*, mentioned by almost seven in ten of the correspondents. Most often the impulse is attributed to individual or family problems: parents who "don't care enough," a stressful home situation, the "generation gap," pressures to achieve.

Elizabeth Herzog (right), **Cecelia E. Sudia,** and **Jane Harwood** were all with the Children's Bureau research division when they began working on the second study in the *Youth Reports* series, of which they give a preview in this issue. Miss Herzog, after 16 years with the Children's Bureau, last April joined the social research group of George Washington University. Still with the Children's Bureau, Mrs. Sudia and Miss Harwood are respectively research analyst and research assistant.

For many teenagers, drugs are the only way to escape the chaotic situation around them . . . . With drugs, they hope to be who they want, where they want, when they want . . . .

However, about one in ten attributes the escape impulse to despair with the world and the social problems that seem unsolvable—"questions which adults either cannot or are afraid to answer . . . race, religion, economics, sex, etc."

The impulse to rebel appears about one-third as often as the impulse to escape. Teenagers who turn to drugs to satisfy or express rebellion are pictured as wanting to challenge the law, defy parents and other authorities, retaliate against prim and prudish regulations.

Kids do things because they are forbidden, because they want to find why it is forbidden.

About one in ten relates drug use to inner psychological problems—isolation and loneliness, identity confusion, loss of direction.

They feel if they tear themselves apart piece by piece they may find the answer.

Mentioned with equal frequency is the problem of "nothing better to do," boring routine, a surrounding emptiness.

There is *nothing* a young person sees as more frightening than a life of dullness and endless routine. I think this feeling comes from the routine we must bear in school.

More correspondents mention "positive" than "negative" reasons for drug use, but the great majority (about seven in 10) mention both types.

"Positive" reasons for drug use. Three "positive" reasons for drug use appear with almost equal frequency, each being mentioned by about two in five correspondents: (1) status or image—a desire to "look big," "be cool," "show one isn't chicken;" (2) conformity—a need to follow the crowd, be accepted, achieve "this belongity;" (3) curiosity—a desire to "see what it's all about."

In my opinion, people who use drugs are using them to get a place in society. Guys think they're tough and girls will idolize them. Girls think guys will like them because they're not chicken.

The teenagers that use drugs probably do so because they want to see what it is like. . . .

Almost as frequently mentioned is the search for excitement—the wish for "kicks and thrills."

More and more of my friends are now using acid . . . it's just more exciting than the ordinary school day according to a boy in class with me who drops acid at least three times a week.

About one in five mentions the reach for aesthetic rewards—the wish to expand the mind and senses, to enhance creativity and insight, to revel in "the overwhelming sense impressions." One includes "religious ecstacy" and another "improved sex."

Others take drugs because of want to be artistic and explore a new world. So use the drug to benefit from it to look at life in a different perspective . . . I can understand using a drug for this reason but no other.

Reasons for non-use

While the correspondents more often mention "positive" than "negative" reasons for drug use, the picture is reversed in their explanations of non-use, although about half give both kinds of reasons. That is, the tendency is to stress what non-users want to avoid rather than what they seek.

"Negative" reasons for not using drugs. What these teenagers want to avoid above all is the harm that drugs can do to the user. Almost four-fifths mention aspects of damage wrought by drugs. These are psychological, social, physical, legal, and moral.

Often the reference is general—"it would be stupid;" "it could ruin your life." Equally often specific dangers are noted: physical danger—about one in four; fear of getting caught—over one in five; mental impairment—nearly one in five; addiction—one in eight; the possibility of a "bad trip" and its recurrence—nearly one in ten; the possible effects on one's future children—about one in ten.

The facts show certain drugs could cause permanent damage to the mind and body. Not many people would want to ruin their life just for a few kicks.

. . . These [bad] trips are like nightmares. You see bugs crawling all over you, walls ready to cave in, a stampede of animals coming straight at you.

A very few correspondents (six) report fear that drug use might lead to a life of crime.

"Positive" reasons for not using drugs. The leading "positive" reasons given for non-use of drugs by teenagers relate to *strength and security*, psychological and social. The non-users, according to about one in three of the correspondents, are the ones who have inner strength, who have goals, who are busy with interesting or worthwhile things.

. . . But the biggest reason I believe is they like life like it is, and not a fantasy of life.

A sense of identity or autonomy in non-users is mentioned by about one in four. Teenagers who do not use drugs are described as not "needing to be different;" they "already know who they are."

I want to be me, not just another drug user.

A similar proportion give credit for drug resistance to family and social supports. Parental example, prohibitions, and disapproval are mentioned, as is "a good family life." Equal emphasis is put on the role of "good friends who aren't on drugs." Good families and friends are seen as protections from the pressures that drive young people to drugs and as strong influences in resisting an impulse toward drug use.

All of us [report of 12 friends] have been offered drugs or come into contact with someone who uses them. It is up to the individual's standards whether he uses them or not. In other words, it depends on your parents and friends, the people who influence you.

Moral or, occasionally, religious principles are mentioned by about one in eight.

A person who really loves God will love his fellow man, will take on responsibility rather than shun it.

Equal mention is devoted to a preference for "other kicks," described as far more "rewarding and REAL." "Other forms of renewal" and "other ways of relieving pressure" include athletics, dramatic clubs, hobbies, enjoyment of the arts, walks in the countryside, "marching for peace."

. . . We haven't felt [drugs] necessary because we have been trying to do something about the things which we feel are wrong today. We have marched for peace, campaigned at conventions, negotiated on high school campuses, and hoped for results.

"Neutral" reasons

Several reasons for drug use or non-use can be regarded as "neutral" in the sense that they do not represent an impulse to move toward or away from something.

Substitute for alcohol. About one in eight of our correspondents report that young people seek in pot what others seek in alcohol. Some of them say pot is preferred over alcohol because it is less "harmful," does not cause a hangover, is "cleaner," or "a lesser evil." Such comments are often accompanied by expressions of disgust for adults who freely indulge in drinking or cigarette smoking and then object to teenagers smoking pot.

Don't sit in front of him with a cancer stick (cigarette) in your mouth and a glass of liquor in your hand and tell him not to smoke pot. Who is to say that your cigarette and liquor won't kill you before his pot will kill him.

But there is a contrasting resentment that in some communities drugs are much easier to obtain than alcohol.

To buy liquor you first need a draft card as proof and then must look 18. To get drugs all you have to do is walk up to anyone at school and ask them if they have any idea where to get them. . . .

Availability. A number of correspondents (nearly one in ten) attribute use of drugs to the ease of obtaining them. About the same number attribute non-use to the difficulty of obtaining them. Both groups are saying that use or non-use of drugs is influenced by the degree of their availability.

It is really surprising . . . how easy it is to get. All you have to do is walk out into the park . . . and you get all kinds of offers . . . . If you know the right people you could get some hashish or marijuana in about five minutes.

One . . . boy announced he had LSD for sale right in the middle of a classroom.

The cost of drugs. Four Youth Reporters give as a reason for drug use that teenagers have too much money. However, others (nearly one in eight) report that the high cost of drugs deters young people from using them.

Also the price is very high for these drugs. For a small pill of acid which is the same size as a baby aspirin, it costs $10 or more. For 2 oz. of pot it costs $5.

Ignorance. About one in 20 attributes the use of drugs to lack of knowledge about their harmful effects and about legal penalties for using them. However, statements that most teenagers do know about the dangers of drug use are far more frequent.

Counter-points. Most of the points made frequently are contradicted by at least a few reporters. For example, one in twenty Youth Reporters denies that drug use is prompted by a desire to escape.

I am sure that the old "escape reality" bit is a lot of boloney.

Several doubt at least one of the other frequently

given reasons—rebellion, conformity, social pressures, curiosity, desire to be tough.

. . . In many cases I suppose the user himself doesn't know why he's doing it.

Do's and don'ts

Nearly every correspondent suggests ways to decrease drug use. These fall roughly under three headings: (1) legalization of drugs; (2) education and persuasion; (3) other programs. Over half the correspondents say directly, and many others imply, that adults should engage in such efforts.

The suggested question "Should adults take steps to discourage the use of drugs . . ." really got me. Is the adult generation so scared of upsetting youth or doing anything they think will give the youth something else to be upset with them about?

However, almost one in five advises parents not to attempt persuasion or influence because they will only stimulate resistance and rebellion.

To legalize or not. Although they were not questioned about this point, nearly half the correspondents report opinions either favoring or opposing legalization of drugs. Of these, about half favor legalization of pot and a few of hard drugs, and about half oppose legalization of any drugs.

The main reason for favoring legalization of marijuana is its alleged harmlessness, in itself, or in comparison with alcohol and cigarettes.

. . . I guess since cars, alcohol and things like that that can be dangerous are legal, we have to have anything else that can damage added to the list.

A very few reporters suggest that legalization of hard drugs would decrease their use because it would discourage "pushers," who "would not be getting rich on it," and the "rebellion" would be eliminated. They also maintain that drugs would be less contaminated, and crimes committed to get money for drugs would be reduced.

Those who would legalize at least some drugs call present laws archaic, inconsistent, and "stupid," especially in their failure to differentiate between different kinds of drugs and in meting out sentences to people who "are sick and need help—not a jail cell." A few also maintain that present laws are ineffectual—"the overwhelming majority [of users] have not been caught by either authorities or parents."

Several reporters point out that favoring legalization does not mean favoring drug use: "rather it would be a step toward minimizing drug use if combined with other methods."

Any crackdown on illegal entry of drugs should start with the hard drugs and work down. Attempts to eliminate, say, marijuana, without first eliminating the more dangerous drugs drive the users of marijuana to, say, heroin.

Many of those favoring legalization imply that penalties for smoking pot should be reduced, if retained at all, some of them specify that penalties for the use of harder drugs should not be reduced. Those opposing legalization are more inclined to stiffen present penalties, especially for hard drugs.

Reasons against legalization include the argument that it would increase drug use just as alcohol use was increased by repeal of prohibition; that marijuana may be an unrecognized health hazard "like cigarettes;" that young people should be protected for their own good.

Most people are sensible enough not to use drugs, but the small percentage who are not smart enough to realize the harm drugs cause should be protected.

Consumer vs. supplier. Bitterness against profiteers also emerges in connection with law enforcement. A few (about one in 14) vehemently urge that there be more differentiation between those who use drugs and those who sell them. Let the police crack down on pushers, smugglers, they say, and one correspondent adds, on the big drug companies that "ship vast quantities of dangerous drugs to Mexico" that are then shipped back to the American black market. A few recommend the death penalty for "pushers."

. . . The government should stop playing around with busting up "pot parties" here and there and crack down on these Mafia and underground groups that are getting rich on messing people up.

What to do

Aside from recommendations concerning legalization of drugs, the suggestions about what to do to diminish drug use tend to be vague and general. Nine out of ten correspondents suggest education and persuasion. However, the fact that nearly half manifest some degree of acceptance of marijuana indicates that these suggestions often—though not always—refer to hard drugs only.

The most frequent suggestions are for school programs—courses, films, speakers, and in a very few instances, the inclusion of parents in such programs. Next come community programs or seminars.

I, myself, have been tempted. Why? Curiosity. Nobody shows us the terrible results that become of drug users. You hear of them, but never see them. I wish we could have a course in drugs, but no one will be bothered.

A few correspondents recommend that public service spots and documentaries be carried on television to have the same "gut impact" as the "cigarettes—they're killers" campaign of the American Cancer Society. Some (one in eight) refer to an educational effort that had a definite deterrent effect on themselves or their associates—a talk given by a former addict, a television or radio program, a journal article, a visit to a rehabilitation center.

The reason that drugs is a bad subject around our school is because of the good movies we have seen through the various classes. They actually make you sick to look at . . . .

Favorable comments on educational programs experienced are twice as frequent as derogatory references such as "teachers talk but who listens?" or "the students know more about the effect of drugs than the instructor."

How to do it

While opinions about what to do are for the most part vague, comments about how to do it are specific. There is real conviction in the following frequent warnings: (1) that advice and instruction must come from the right sources; (2) that the emphasis must be on facts, evidence, and experience; (3) that emotional exhortation must be avoided.

The right source. Over one in three correspondents say that unless information and education about drugs come from the right person, they are likely to be futile. The "right person" is variously described as one who is able to listen to and communicate with young people; who "really cares;" who is trusted and respected, and who "knows what he is talking about."

With regard to age, opinions differ. A few insist on youth in "the right person," but the descriptions most often imply that experience, information, attitude, and approach are more important than age. Parents, teachers, counselors—if they meet the specifications noted—are included, as are physicians, social workers, town officials, policemen, and former addicts. However, one or two advise "no cops."

Facts, evidence, experience. The strongest emphasis seems to be placed on the demand for facts. Don't preach, these young people advise, don't exhort, don't get emotional, don't tell us what to do and what not to do. Just give us the facts and let us make up our own minds. Moral precepts, warnings, or orders are "ridiculous."

Proof of harms of drugs should be shown to them. Not just saying "Don't take drugs." This is wrong. People must be shown why not to for it to be effective.

Parents and peers. A substantial minority of the correspondents rule out parents as effective anti-drug-use educators, but a more substantial minority rule them in, indirectly if not directly.

If parents are good parents, they say or imply, their children "will choose the 'no-drug' route for themselves." Parents should give love and understanding, be aware of their children's associates, teach them that drugs are "not exciting but dumb," set a good example, teach their children "how to face the world and its problems;" and, if they do discuss drugs, should know what they are talking about, according to these Youth Reporters. Moreover, parents should refrain from putting pressure on young people to achieve. Furthermore, they should work to right the social wrongs that make people seek escape through drugs.

Drugs are a problem which may never be solved completely. But perhaps, if the parents of the child show understanding, maybe the youth will not be so apt to escape. If his life is good, he will not need the artificial thrills. . . .

Some young people not only deny that parents have a role in discouraging drug use but award them an important place in promoting it—sometimes by example, more often by failing in their parental role.

The importance teenagers attach to peer groups is evident in these reports, especially in the strong emphasis they put on status and conformity as reasons for drug use and on peer influence and lack of peer pressure as reasons for non-use. The general assumption seems to be that if either the family or the peer group exercises a very strong force, it can prevail over the other.

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[1] Herzog, Elizabeth; Sudia, Cecelia E.: The generation gap in the eyes of youth. *Children,* March–April 1970.

[2] Herzog, E.; Sudia, C.; Rosengard, B.; Harwood, J.: Teenagers discuss the generation gap. U.S. Department of Health, Education, and Welfare, Office of Child Development, Children's Bureau. Youth Report No. 1. 1970.

[3] Herzog, E.; Sudia, C.; Harwood, J.: Youth reporters discuss "problem drugs." U.S. Department of Health, Education, and Welfare, Office of Child Development, Children's Bureau. Youth Report No. 2. (In press.)

ADOLESCENCE, IDENTITY, AND FOSTER FAMILY CARE

J. MCEWAN MACINTYRE

In the United States, on any given day, a quarter million children are living in foster family homes; about half of them will probably spend a major part of their childhood years in foster care. In addition to having to cope with the emotions aroused within themselves by being sent away from their own families, these children are faced with the need to get along with a new set of parent figures and perhaps also with a new set of brothers and sisters, new neighbors, new teachers, and new classmates. When such a drastic change takes place in adolescence, it comes at one of the most critical stages of development. The way it is handled may be crucial to the young person's future relationship to himself, to other persons in his life, and to society in general.

To appreciate the kind of double crisis facing adolescents in foster care—the developmental crisis of adolescence itself and the personal crisis of being uprooted and transplanted into an unfamiliar human environment—one needs an understanding of Erik Erikson's concept of identity, a concept that Erikson has clarified and expanded over the years since he first introduced it in 1950.[1-6]

Erikson's theories are an extension to the psychological sphere of the biological concept of epigenesis. Epigenetic development is characterized by a series of sequential stages, each of which must appear in an orderly sequence and in a definite rhythm of growth for optimum adaptation during the entire life cycle. In his theory of personality (or ego) development, Erikson presents the first psychoanalytic theory to encompass the total life cycle as a progression from infancy through early childhood, preadolescence, adolescence, adulthood, maturity, and senescence. His underlying assumptions are: (1) that the human personality develops according to steps that are predetermined by the growing person's readiness to be driven toward, to be aware of, and to interact with, a widening social radius; and (2) that society attempts to meet and invite this succession of potentialities for interaction and to safeguard and encourage the proper rate and the sequence of their unfolding.

Erikson describes eight stages in the life cycle, each characterized by the necessity of resolving a specific developmental crisis, a task that must be accomplished to some extent before the individual can proceed to the next stage. While admitting that complete resolution rarely, if ever, occurs during the critical stage, he presents his theory in the hypothetical extremes of successful and unsuccessful resolution; for example, the development of basic trust or mistrust. The word "crisis" is not used in the con-

ventional sense, rather it indicates characteristic critical points, the resolution of which lead the personality on to further progress and integration, or, if unresolved, to regression.

Identity formation

Erikson perceives identity formation as evolving throughout childhood and adolescence through synthesis and resynthesis of the sense of self into a configuration that gradually integrates "constitutional gains, idiosyncratic libidinal needs, favored capacities, significant identifications, effective defenses, successful sublimations, and consistent roles." [2] Such a configuration derives from "a process of simultaneous reflection and observation . . . by which the individual judges himself in the light of what he perceives to be the way in which others judge him," while he regards their way of judging him "in the light of how he perceives himself in comparison to them and to types that have become relevant to him." This process is unconscious for the most part, except in situations in which "inner conditions and outer circumstances combine to aggravate a painful or elated 'identity-consciousness.'" [6] At its best, identity formation is a process of increasing differentiation that becomes ever more inclusive as the individual grows aware of a widening circle of other people who are significant to him—all the way from the one maternal person to "mankind."

The sense of identity that the person gains is "the accrued confidence" that one's ability to maintain inner sameness and continuity is matched by the sameness and continuity of one's meaning for others. Thus self-esteem, affirmed at the resolution of each major crisis, becomes "a conviction that one is learning effective steps toward a tangible future, that one is developing a defined personality within a social reality which one understands." At each step in his developmental process the child must "derive a vitalizing sense of reality from the awareness that his individual way of mastering experience is a successful variant of the way other people around him master experience and recognize such mastery." [3] The dominant developmental goal is for "the active selective ego" to be in charge and to be "enabled to be in charge by the social structure." [5]

Erikson's identity concept is focused on the fusion of the elements of identification, capacity, ideals, and opportunity into a viable self-definition. The assembly of all these elements is a formidable task for an adolescent. If this task is not accomplished, he faces the danger of identity confusion or identity diffusion—the failure to establish a sense of self-worth. At adolescence, development involves processes of identifying with persons significant in one's life and with ideological forces. These processes together give meaning and importance to individual life "by relating it to a living community and to ongoing history, and by counterpointing the newly won individual entity with some communal solidarity." [5]

While identity formation does begin long before the adolescent years, the adolescent must achieve a complicated task of synthesis. He must relate his earlier identifications with his own personal qualities as he now assesses them and to the social ideals and the opportunities available to him. What the youth is to become—in the sense of strength of personality—is influenced by what his environment has permitted and now permits and encourages, and his own talents, needs, and defenses.

Problems of foster care

How then can adolescents in foster care accomplish their developmental task?

Erikson maintains that to achieve a feeling of identity—or inner solidarity—a young person must gain "a sense of inner continuity and social sameness which will bridge what he was as a child and what he is about to become." [2] Most adolescents go through some inner turmoil while struggling for this goal. How much harder then must it be for foster children whose childhood has been disrupted by removal from their homes and perhaps again from one foster family to another? No wonder many of them have trouble incorporating their past and present experiences into an integrated picture that suggests the possibility of constructive, satisfying experiences in the future.

Numerous studies have shown that children in long-term foster care usually experience two or three placements and that the more placements they have experienced, the more problems they present.[7-10] Other studies have shown that the length of time in foster care also is related to the incidence of behavior problems, but that this incidence is less among children whose own parents maintain contact with them.[11, 12] Such findings suggest that when a child's parents keep in touch with him, the child's feeling of having been rejected is lessened. Studies have shown that when a foster mother exhibits a hostile attitude toward the child's own mother rather than accepting her as a significant person in the child's life, the probability of the child's doing poorly in the foster

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home is increased.[13] Apparently the child needs to have repeated assurance from his own parents about his background so that he can perceive himself in relation to his parents and in relation to himself at an earlier age.

In her follow-up study of adults who were foster children, Elizabeth Meier [14] gives clear evidence that the removal of children from their own homes has a negative effect on their ability to form an adequate sense of identity, especially if the children are boys. Her data on the men in her study suggest that when a boy spends a major part of his childhood away from his own family, the resultant damage to his self-image may make it difficult for him later as a man to maintain a marriage or carry on successfully in the world of work. The young women in Meier's study seem to have done better, judging by their ability to perform their roles as wives and mothers. The data suggest that the quality of their experiences in foster care was of greater importance in their development than the fact of having been in foster care. The members of both sexes, however, demonstrated a lesser sense of satisfaction than their achievements would seem to warrant. Most of them gave no evidence of having a feeling of "inner assuredness," which Erikson regards as indicative of an optimal sense of identity.

Maas and Engler found abundant evidence that children who move through a series of families or are reared without close and continuing ties to a responsible adult have more than the usual problems in discovering who they are.[8] Such children tend to develop only shallow roots in relationships with others; they try to please others, but cannot trust them, or they strike out against others before they can be let down. For these children the environment has not been consistent enough to allow them to construct a coherent picture of positive relationships. Their ability to trust others is impaired to the point of hampering the development of their own trustworthiness. Because of frequent fundamental changes in their lives, they are unable to build a sense of inner sameness and continuity.

Erikson suggests that a wholesome concept of self includes recollections of the past, awareness of present realities, and expectations of the future. Parents generally think about their children as growing individuals who will one day be young men and women. They remind the children of this frequently, they promise the children future privileges, and they urge the children to do certain things *now* in preparation for future demands. Thus the children gain a sense of continuity.[5] The foster child, however, may realize that neither his foster parents, his social worker, nor any other responsible adult in his present experience expects to be a continuing part of his life in the future.[14]

Even when there is no overt trouble in the foster home, the continuity of the child's experience may be at risk, for changes in circumstances may occur within the foster family—illness in the family, pregnancy of the foster mother, or the arrival of a relative, such as an aging parent who needs the child's room. Pointing to such contingencies, Elizabeth Glover described the foster child's status as having "a potential lack of stability." [15]

Implications for service

In spite of these hazards to identity formation, foster family care is necessary for thousands of children and will continue to be necessary for some children whether or not important improvements are achieved in services to prevent family breakdown, to maintain family health and income, or to provide better housing, all measures that could conceivably reduce—but not eliminate—the need for foster care. This prospect raises the question: "How can foster care promote, rather than impair, the foster child's sense of identity?"

This question has special relevance for the child whose foster care is prolonged, for he is the child whose ability to achieve a strong sense of self is most likely to be impaired.

The following five suggestions, none of them new, are worth renewed emphasis:

1. ***Avoidance of replacements whenever possible.*** This requires adequate decisionmaking at the time of the first placement. Such decisionmaking, in turn, may require:

- ***Participation by the child*** insofar as possible, as

well as his parents, not only in the decision to place, but also in the type of placement to be made. Adolescents particularly may be more amenable to the placement if they feel they have had some say in the choice, or at least, that their opinions have been solicited and respected.

● A look at a ***wider variety of living situations*** than is customary among many child welfare agencies. A few agencies, for example, are beginning to recognize the following possibilities: (1) ***the establishment of agency-owned and operated small group homes*** housing four to six children or adolescents under the care of foster parents who are full-time, paid employees of the agency; and (2) ***the wider use of middle and upper-class families*** as foster parents of children who are unlikely to be returned to their own parents.

In Washington, D.C., for example, the Family and Child Services has employed a number of couples to care for four or five children each in houses bought or rented by the agency.[16] In this type of arrangement, foster parents, regarding themselves as permanent employees of the agency, are more likely to weather the ups and downs of a child's reactions to separation from his parents and to work closely with the agency in his behalf. As a result, the child may be less likely to sense a shaky balance of mixed feelings on the part of those who care for him and so may feel more secure. Some authorities have suggested that it may be "a mistake to think that love and money are mutually exclusive; particularly if the need for money can be linked with a third important motive, pride in doing a job well." [7]

At least one agency has experimented, with some success, in aiming a campaign to recruit foster parents within relatively affluent groups,[17] but such efforts are rare. While child welfare workers usually look to upper middle-class families for adoptive homes, they generally do not regard such families as resources for the foster care of children. Nevertheless, as Annette Wigod has pertinently noted, "Disadvantaged children require—and deserve—the most nurturant, the most restorative environment our affluent society can provide." [18]

2. ***The maintenance of parent-child relationships.*** Even though a child or adolescent does have to be removed from his own home, he should be afforded opportunities to see his parents regularly, unless circumstances indicate that his own protection demands the termination of parental rights through court order. If the child is placed in the same community in which his parents live, he can visit in his home and also maintain relationships with some of his friends from his home neighborhood and school. Another means of helping adolescents maintain or regain relationships with their own families might be through the use of "halfway" foster homes that would allow them to spend weekends, holidays, and other special occasions at home with their own parents.

There is some, but not very much, recent literature on continuing work with the parents of foster children with a view of achieving a possible reconciliation with their children.[19, 20] Many parents have no contacts with the child-placing agency after placement, or even with their placed child. Because few agencies exert much effort in trying to strengthen the parents' ability to function as parents, many children who might otherwise be happily reunited with their families spend their childhood in foster care. Perhaps many parents cannot be helped to become more responsible or effective parents because the social work profession lacks the knowledge or skill to help them, but perhaps, too, more parents could be helped if the child-placing agency would raise its sights to encompass a view of the parents' needs as well as of the child's. In reaching a placement decision with a child's parents, the agency needs to make clear its expectations that they are to have regular interviews with a caseworker and to make plans for the child's possible return home.

3. ***Education of the foster parents in principles of child development.*** Foster parents might help children retain and develop further their sense of identity if they understood the process of identity formation and the importance of roots for the child. With such understanding they would be less likely to take a disapproving or hostile attitude toward the child's own parents—attitudes that can be devastating to the child's sense of self-esteem no matter what troubles he has had with his parents. More and more agencies are using one-to-one supervision, group meetings, and special courses to help foster parents and prospective foster parents understand the special needs of children in foster care.[21-22] At least one agency has made arrangements for adolescents who are in foster care to attend meetings of prospective foster parents to tell them what it is like to be a foster child.[23]

4. ***Group meetings of adolescents in foster care.*** Giving groups of youths in foster care a teaching role in the preparation and education of foster

parents heightens their own self-esteem.[23] The same may be true when adolescent or preadolescent children discuss their problems together. A growing number of agencies are sponsoring such discussions.[24-26] Helen Northen, in discussing the group as a problem-solving medium, tells of how one group of foster children worked on problems of "identity, adequacy, and attitudes toward other people" by discussing their views of how their foster parents felt about their parents, the reasons their parents were unable to care for them, and their uneasiness at living with strangers.

5. ***Giving each foster child a dossier of material about himself and his family.*** Meier has suggested this step on the basis of her finding that discontinuities in experience not only cause emotional problems but also deprive the child of the supports that help him know "who he is in relation to other persons, where he has been when he has been at different places, and what has happened to him at different times in his life." She suggests including in the dossier information about the foster child himself and where he was born, his mother's and father's full names, names of relatives he has known, addresses where he lived prior to being in foster home care, names and addresses of foster parents with whom he has lived, pictures of himself at various ages, pictures and letters from family members, report cards, and such other "accoutrements of this age of paper which are used to record the human being's progress through life."[14] Thus the child would have a kind of super identity card.

The task ahead

"A new era in fostering has unfolded," says Mike Grant, a member of a group of adolescents who drew from their own experiences in interpreting foster children's needs to foster parents.[23] Perhaps child welfare workers, who carry the awesome responsibility for child placement and eventual family reunion, will draw from these bright words renewed determination to help children and teenagers find strength rather than despair in the experience of foster care.

Erik Erikson, in describing the process of identity formation and its critical importance in adolescence, gives an indication of how complex this task can be.

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PAT AZARNOFF

A PLAY PROGRAM IN A PEDIATRIC CLINIC

Today many hospitals in this country provide play programs for hospitalized children as an important part of medical treatment. However, only a few pediatric outpatient clinics in the United States provide any activity programs for children and very few of these are conducted by paid staff members.

The experience of the child activities program at the outpatient pediatric clinic of the University of California at Los Angeles illustrates some of the important benefits that such a program can provide.

As the director of the program, I am responsible for arranging the environment, planning the activities, and training volunteers to play and talk with the children. I speak with parents about their children's behavior, accident prevention, toy selection, criteria for choosing a nursery school, and general health information. I also observe patients in spontaneous play to pick up diagnostically important information for the staff.

The basic purpose of the program is to make it easier for the child and his family to come to the clinic and to create an atmosphere in which the child is trusting enough to be cooperative. But there are many byproducts of benefit to the clinic's operations as well as to the child and his family.

In addition to couches and cushioned benches, the clinic's waiting room contains an area furnished with child-sized tables and chairs, small animals and fish, blocks, toy trucks and cars, books, and equipment for playing house. An outdoor play yard, fenced-in and grassy, offers a hill to climb or roll down, a large log for climbing on, a sandbox, tricycles, wagons, a small doll house with miniature furniture and bendable dolls. There are also benches placed under sun umbrellas to encourage parents to be with their children outside. Each of the examining rooms contains a shelf of toys, books and magazines, dolls and blocks.

Instead of sitting fearfully while waiting their turn to be seen by a doctor, or climbing over furniture, upsetting parents, and being noisy or destructive, the children can play with toys and equipment selected to interest them. The pleasant physicial surroundings help calm their fears of the medical setting and prepare them to cooperate with the staff. As a consequence, there is less need for the children's parents and the clinic's staff members to spend time controlling misbehavior.

The children often test their ideas about their illness or about the hospital with us.

Susan, 5 years old, told us, "The doctor is going to check my heart today. I had heart surgery. He's going to see if it's still beating, I think."

A 4-year-old girl who had just had a blood test reported, "They made me bleed. They took all my blood." After we sympathized, we gave her a few other ways to consider what had happened.

A 9-year-old boy told us the doctors were going to get "pictures of his health" (X-rays) and maybe he was "dead inside."

We offer the patients and their families nonmedical experiences with the staff, a person-to-person contact in which the child has the chance to give or control the situation. For example, the children distribute popcorn that we make in a popper in the waiting room. Around holidays we make small gifts in craft sessions for each child to give to his doctor or nurse. Or we bake cupcakes and decorate them. The surgeon carves our Halloween pumpkin. The inhalation therapist pumps helium into the

Based on a paper presented at the 1970 convention of the American Association of Child Care in Hospitals.

balloons or punchbag. The gardener asks the children's help in watering the flowers and sweeping the yard.

Diagnosis and training

Members of the medical staff are encouraged to watch the children at play in the waiting room and yard, especially those who are about to be examined. The information obtained from the staff's observation adds a dimension to the diagnostic process and the decisions about therapy.

A physician examined a 10-year-old boy whose arm cast had recently been removed. The child, who had been advised to exercise his arm, had reported that he was using it extensively now. Afterwards, in observing the child at play outside, the physician noted that the boy unconsciously favored the other arm. The physician joined the children's ball game and showed the boy that it was not necessary to guard the arm any longer.

The staff psychologist, who was especially interested in children with school phobia, asked us to put a child, who seemed to be upset about the psychometric testing, in the play area with friends of his own age. The boy visibly relaxed. Soon afterward he returned to the testing situation less fearful and able to perform better.

Students of medicine, psychology, education, special education, nursing, and social work are also given scheduled opportunities for observing and interacting with the children, to improve their interpersonal skills and their knowledge of normal growth and the effects of illness or chronic disability on a child's development.

Screening and prevention

Conversations with parents in the waiting room can result in important preventive measures with the patient. A mother may have brought along other children who may show signs of acute illness or chronic conditions that have not been reported. Or a parent may mention a child left at home because "she was too sick to come to the clinic."

Noting that a 5-year-old girl being held in her mother's arms seemed unusually weak and listless, I asked the mother if she had brought the child in to see the doctor. Shaking her head, the mother said that the appointment was for her son, not her daughter, and that she had made it several weeks before. When I told her that her daughter could be seen immediately by a physician in the Walk-In Clinic, she was obviously relieved. On examination the little girl was found to have a fever of 104 degrees.

After watching us manage disruptive behavior in the clinic, parents will sometimes ask me about ways to handle their children's temper tantrums or other difficult behavior. In such instances I let the parents know that the doctor would be interested in discussing the problem with them.

A child may be so active that the mother is exhausted, but she believes that the child's behavior is the result of her faulty attempts at discipline. Perhaps her parents or husband have been blaming her, too. When this kind of hyperactivity is observed while the child is at play, a neurological examination follows and medication may be prescribed.

Parent education

Many of the families who use our clinic come repeatedly. We get to know them well enough to

A guinea pig in the children's waiting room of UCLA's Outpatient Clinic attracts the attention of two young patients.

talk informally and easily together when questions come up. Our bulletin boards display easy-to-read health information in both English and Spanish. A mother engrossed in reading a magazine, for example, may not notice her toddler playing with the ashtrays, tearing up magazines, or jumping from the furniture. When we bring the mother a toy to offer to her child, we are not only preventing possible difficulties at the moment but also making ourselves available in case she wishes to talk about the child.

The mother may say, "I guess he is playing with the cigarettes, but nothing we ever give him keeps his attention." We may suggest the substitution of safe toys for unsafe objects. Instead of picking up ashtrays and playing with the ashes and tobacco, the child can have a shoe box of sand or sawdust. Instead of turning lights on and off, the child can have a flashlight.

Parents who stay in the play area with their children can learn how their children behave with other children, or can discover simple games and crafts to try at home.

Because play is a natural activity for children, the play area is ideal for demonstrating points about child behavior to parents.

A mother who was concerned about the "hyperactivity" of her 2-year-old was sent by the doctor to the play yard so she could see her own child next to others. After watching other 2-year-olds moving the toys around, failing to put things back where they belonged, and always being "on the move," she seemed to understand better the relation of behavior to the natural process of growing. We talked about the possibility of rewarding the curiosity of her child and setting limits on the kind of behavior that must be controlled.

We use many homemade toys and equipment not only to keep within our budget, but also to offer parents models that are easily duplicated at home. We show the children how to plant seeds, such as grapefruit, orange, or apple seeds or kidney or lima beans. On return visits to the clinic, children are encouraged to take home the plants that grew from the seeds they planted.

The children decorate oatmeal boxes from the hospital kitchen to make drums that they can take home. They cut pictures from magazines, paste them on cardboard, and then cut them into pieces to make puzzles. A decorated carton that a toddler can climb in and out of is always available.

Besides demonstrating these easily made items, we talk with parents about the possibility of getting their children longer-lasting toys such as tricycles, child-sized kitchen furniture, or dress-up clothes, dolls, trucks, and construction toys.

We also use the children's behavior at play to involve parents in discussions of appropriate behavior.

One mother allowed her 3-year-old child to throw toys at other children and to bite others when he was angry. The mother had read that children need outlets for their anger. There was no time to talk with the mother first. We stopped the behavior by diverting the child's attention to something else. Then we talked with the mother, discussing other possible outlets for anger and the importance of looking for its causes.

With the help of a clinic volunteer, a child uses a stethoscope "just like the doctor" to listen to his beating heart.

Child care

Most clinics know the problem of cancelled appointments. Sometimes the problem arises because at the last minute the mother did not have a place to leave her other children. In our clinic a mother can bring her other children along without being overwhelmed by the necessity of keeping them out of mischief while trying to talk to a staff member about the child brought in for medical attention or just waiting his turn to be examined. The volunteers in the child activities program will help her care for the other children. In helping parents, by changing

diapers, feeding babies, or watching active children, the volunteers always take the lead from the parents as to how much help or what type of help they want. The parents are encouraged to do as much as they can themselves and to use the volunteers' assistance when needed.

When social workers, psychologists, or physicians wish to speak with a mother alone, especially after a diagnosis of a difficult nature, or because extensive explanations are needed, her children are sent to the play area. There they are supervised until the mother returns for them.

Because of the importance of parental visits to the morale of a hospitalized child, the outpatient play area is also made available to parents who need some place to leave other children while visiting a child on the inpatient ward. This not only makes it easier for parents to visit their hospitalized child regularly, but it also provides the staff with an opportunity to help these other children understand what is happening to their hospitalized brother or sister. With the parents' permission, we talk with these children individually, gently correct their misconceptions, and so ease their fears.

We also inform the parents of hospitalized children about the privilege of bringing their other children to the weekly picnic held in our play yard for inpatients on the children's ward. Thus the hospitalized child and his brothers and sisters have a chance to visit with one another.

Public relations

In most clinics there is a waiting period between the time the patient and his family arrive and the time he actually sees the doctors or undergoes the procedures scheduled for him. It seems a paradox to offer high-quality medical care, but provide a waiting room atmosphere that fosters poor mental health. Lines of hard benches, poor lighting, no available food source, no play area for children are not attributes of excellence of care. Moreover by discouraging clinic attendance, they prevent children from getting the care they need. Many parents have remarked that they bring their children to our clinic because they know that when they get there someone will care about how comfortable they are, and the atmosphere will be conducive to health, not tension.

In the play corner in the pediatric clinic's waiting room children re-create some of the everyday events of home life.

A child activity program is only one type of auxiliary service pediatric clinics could offer. In our clinic we are beginning to offer some others: teaching child care to older children who are left in charge of younger children in the waiting room; providing health education to the community through films, slides, tours, and talks; holding discussion groups for parents, teenagers, and siblings of chronically ill or mentally retarded patients; and developing health manpower through training volunteers and students. Many of these efforts are offshoots of the child activities program.

With a clinic staff interested in the psychology of illness and crisis, with administrators willing to provide the necessary salaries, space, and budget, and with a volunteer program available to recruit, screen, and continuously train volunteers to help, a child activities program can show its worth. This is being demonstrated every day at the UCLA pediatric clinic.

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CHANGING PROSPECTS FOR CHILDREN WITH HEMOPHILIA

KENNETH M. BRINKHOUS

Until recently the chances of a child afflicted with a severe case of hemophilia living to adulthood without serious crippling, or having a normal life if he did so, were slim. This hereditary disease of uncontrollable bleeding afflicts mainly males. Made famous by a strain that runs through the royal families of Europe, it has meant for its victims pain, crippling, the necessity of repeated hospitalization for blood plasma transfusions, and constant threat of death from bleeding into the brain, air passages, or other vital organs. It has also brought its victims severe social and psychological problems, stemming from their inability to lead normal lives.[1, 2] Now, however, the prospects for the hemophilic child are much brighter because of a revolutionized method of care made possible by the recent development of blood plasma concentrates.

With early diagnosis, prompt treatment, and proper management, life-threatening hemorrhages in hemophiliacs can become a thing of the past. A few boys and young men who have hemophilia are already receiving the plasma concentrates prophylactically for the prevention of hemorrhage, much as the diabetic receives insulin. The concentrates must be given by intravenous injection. This treatment has completely changed the way of life for its recipients. They now can attend school, play, go to work, and live much like normal males of the same age. The life expectancy at birth of a hemophilic child—once estimated at 18[3]—may now approach that of normal boys.

But many problems still stand in the way of a normal life for most hemophilic children. A continuous alert for the occurrence of hemorrhages and their prompt treatment must be maintained. Moreover, supplies of plasma concentrates are limited and expensive; it is not unusual for a child with hemophilia to use plasma concentrates costing $12,000 a year.

How many persons there are in this country with hemophilia is unknown. Estimates range from between 10,000 and 15,000 for those with severe forms of the disease up to 100,000, including all who may have a mild form. Many mild bleeders are unaware that they have hemophilia until major surgery or a serious accident reveals deficiency in the clotting of blood. The National Hemophilia Foundation estimates that 40,000 boys and men in the United States have moderate or severe forms of the disease.

The disease

Hemophilia is a disease of males, inherited through the mother, in whom the blood plasma lacks a specific trace protein that produces clotting. The two main forms, hemophilia A and hemophilia B, cause similar symptoms. However, they differ in the specific types of clotting protein that is missing in the blood.

Hemophilia A occurs five or six times as frequently as hemophilia B. The general impression among physicians is that hemophilia B is not as severe as hemophilia A. Patients with hemophilia A seem to require hospitalization and transfusions more frequently than those with hemophilia B.

Both types of hemophilia show up in the same way. The baby boy with hemophilia may bleed excessively when the umbilical cord is cut at birth or after he is circumcised. Parents notice "black and blue" marks and bruises on the infant's body. When the child starts walking and running, troublesome and persistent bleeding into the large joints causes painful swellings, especially of the knees and elbows. Once a joint has been the site of a severe hemorrhage, recurrences of bleeding in the joint are frequent.

Bleeding episodes may occur after mild trauma; many, however, may occur unpredictably. The possibility of serious internal bleeding in one form or another haunts the hemophiliac throughout life.

Problems of impaired emotional and social development often arise in the school-age hemophilic child because of his irregular attendance at school and overprotective environment at home. These problems often carry over into adult life. Such problems may later be reflected in the adult hemophiliac's social adjustment and ability to hold a job.[1, 2] With the birth of a hemophilic child, the whole way of life of a family can be greatly affected. This is dramatically demonstrated in Massie's recent best seller, *Nicholas and Alexandra*,[4] which depicts the effect of the young czarevitch's hemophilia on the course of Russian history.

Methods of inheritance

Both A and B types of hemophilia stem from genes that follow a sex-linked pattern of inheritance according to Mendelian law. The male inherits the disease through his mother, who carries the gene for hemophilia but is otherwise normal. There is no father-to-son transmission.

The hemophilic gene is located on the X-chromosome, one of the two chromosomes that determine sex. The other is called Y. A child with two X-chromosomes, XX, is a female; if one of her X-chromosomes carries the hemophilic gene, she is a carrier of the disease. A child with one X-chromosome and one Y-chromosome, XY, is a male; if his X-chromosome carries the hemophilic gene, he will have hemophilia.

A female carrier, with one affected X-chromosome, is protected from the disease by the accompanying normal X-chromosome. Geneticists can predict the average composition of the families of both hemophilic males and carrier females by sex and hemophilic status. For example, a man with hemophilia married to a normal woman will have all carrier daughters and all normal sons. A woman carrier of hemophilia married to a normal man could have four children distributed as follows: a normal daughter, a carrier daughter, a normal son, and a hemophilic son.

In small families the distribution of children by sex is often very different. Hemophilic men may sire only two children, both sons. In this case, there is no transmission of the disease to later generations. Women who are carriers may give birth to three children—all sons, all with hemophilia. Conversely, while a carrier may have three normal sons, such a remarkable event would probably go unrecognized, since the carrier status of the mother would likely not be known. Only if she also has a carrier daughter who eventually gives birth to a hemophilic son would the true situation become apparent.

Some progress has been made in detecting the carrier state in women before the appearance of a hemophilic son. A laboratory test has been developed to measure the amount of the clotting protein or antihemophilic factor in the blood. Women with hemophilic children have been found on the average to have only half as much of the clotting protein in their blood as do their normal sisters.

Laboratory testing, however, involves several problems. The test itself is difficult and expensive to carry out and requires special laboratory equipment. Even with reliable laboratory results, accurate interpretation of the test is not easy. One pitfall lies in the fact that not all carriers have a 50–50 distribution between blood cells that can and cannot produce the clotting protein. For example, if a woman has only a few cells that cannot produce the antihemophilic

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protein, the level of the clotting factor in her blood is in the low normal range although she is a carrier. Also, the use of birth control pills may increase the amount of the hemophilia A clotting protein in the blood of some women, which could further complicate interpretation of the test.

A family history of hemophilia, combined with laboratory testing for low levels of the clotting protein in the blood, provides the most reliable basis for predicting that a woman is a carrier. Many women who have been tentatively identified by laboratory tests as carriers of hemophilia have later confirmed the diagnosis by giving birth to a hemophilic son. At the present time, however, screening the general population of women to find carriers of hemophilia is not feasible.

Some women have given birth to hemophilic children although there was no history of hemophilia in their families. In fact, roughly one-third of the families with hemophilic children are in this category. How did they become carriers? There is no simple explanation. Some of these persons are undoubtedly mutants—that is, their mothers were not carriers, but one of their own X-chromosomes was changed in some unknown manner. On the other hand, with small families the hemophilic gene can be submerged in the genetic pool for long periods of time and a family line may not have a hemophilic son for many generations. Before the potential seriousness of the hemophilia problem is assessed for a woman identified by laboratory tests as a carrier, the findings need to be correlated with her family history.

Many men have a mild form of hemophilia that is not troublesome except at times of operations and accidents. If correctly diagnosed, the mild disease can be readily managed medically. Female carriers of the mild form show low levels of clotting protein in tests, just as do carriers of the severe disease.

Family planning in hemophilic families presents special problems. Limitation in family size is the rule followed by most families once the disease appears. The prediction of carriers can be of real value, by alerting the family early in pregnancy to the possibility of hemophilia.

The liberalized interpretation of abortion laws in many States, combined with application of present knowledge of genetics, offers a means of reducing the hazard of hemophilia in affected families. As a first step the sex of the unborn child must be determined. Early in fetal life this can be done by amniocentesis—the surgical process of tapping the uterus for a small amount of amniotic fluid in which the fetus lives in the pregnant woman. Two methods are used to analyze the fluid: (1) cell culture, which determines whether the sex chromosomes are XX (female) or XY (male); or (2) more simply, the test for the Barr body, a characteristic that is present on the nuclear membrane of female cells.

In families in which the father has hemophilia, if only the males were allowed to come to term, the transmission of the hemophilic gene to a daughter who would be a carrier to later generations would be stopped. If the mother is a carrier, the choices are less clear cut. By having only daughters, she at least avoids the hazard of giving birth to hemophilic sons. In any event where abortion is not prohibited by law, the decision would have to be made on a purely voluntary basis by the parents themselves, after full discussion with their physician.

Development of treatment

That blood transfusions have a corrective effect on hemophilic bleeding has been known for over a century. The first transfusion was given in London in 1840 to a hemophilic boy who was bleeding from an operation to correct a squint in one eye. By modern standards the procedure was crude: a few cubic centimeters of blood at a time were withdrawn from the donor and injected directly into the patient. No anticoagulant was used. The bleeding stopped. But with surgery on other hemophilic patients, the bleeding continued in spite of treatment with blood transfusions.

The effectiveness of transfusions in treating hemophilia was a matter of medical controversy for nearly a century. Physicians who found transfusions effective could not agree on what part of the blood was responsible for clotting—the platelets or the plasma.

In 1947, in research laboratories at the University of North Carolina, we were able to show clearly that the active antihemophilic principle resided in the plasma.[5] We also demonstrated that the antihemophilic factor was well preserved only as long as the plasma was frozen. We made the first application of this observation in our treatment of hemophilic dogs in 1949.[6] Hospital and community blood banks quickly put our findings to use, and fresh frozen plasma became the mainstay in the management of hemophilia for more than 15 years.

Fresh frozen plasma made great improvements possible in the treatment of hemophilia. While it still has a place in treatment today, frozen plasma has serious shortcomings. The main problem is that

normal plasma has such a low concentration of the clotting protein that relatively large volumes are needed to control hemophilic bleeding. Bleeding is not always effectively staunched by this treatment. Moreover, injection of such large amounts of plasma often results in an excessive volume of circulating blood and leads to acute congestive heart failure.

The need for a plasma concentrate that would correct clotting has long been recognized. Preparation of antihemophilic material from animal and human blood was first attempted more than 30 years ago—even before the nature of the active principle of hemophilia was known—but with little success. No advances were made until the antihemophilic factor was identified. Then in 1952 the two types of hemophilia were separated; hemophilia A and B were recognized as separate entities that needed distinctly different clotting proteins for treatment. At the same time laboratory studies produced a suitable procedure for identifying and assaying the antihemophilic factor for hemophilia A. A basic procedure known as the partial thromoplastin time test was developed in our laboratory and is now commonly used for assay and diagnosis of both hemophilia A and hemophilia B.

Many concentrates for hemophilia A, the more common type of the disease, have been developed. Their potency is indicated in two ways. One way is the degree of *purification* of the antihemophilic protein, expressed as the ratio of the antihemophilic activity to the total proteins in the concentrate. The other is the *concentration* of the protein in solution as it is ready to be administered to the patient.

We have divided these concentrates into separate generations, similar to the generation classifications used for missiles, to indicate relative stages of development.[7]

Generation I consists of the first concentrates to be developed, which had low potency. The generation I materials were often less concentrated than normal plasma.

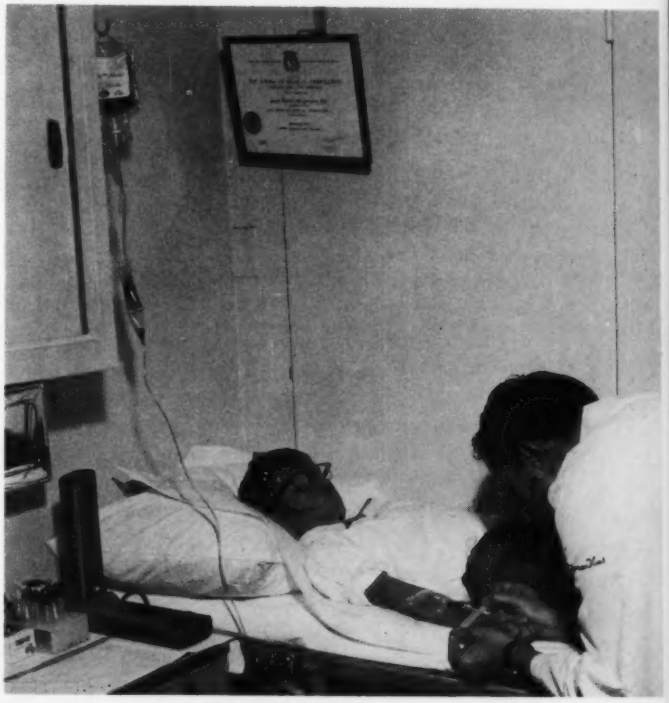
Generation II concentrates are purified 10 to 100 times. When made into solution ready for administration to the patient, they are five to seven times more potent than the same volume of normal plasma.

The development of generation II concentrates was made possible by two discoveries.[8] One was the finding by Robert H. Wagner at the University of North Carolina in 1962 that glycine could be used to separate the clotting factor from blood plasma by precipitation. Concentrates of the antihemophilic factor precipitated in this way were used to treat hemophiliacs in the period from 1962–68. The superiority of these concentrates to fresh frozen plasma was striking; hemorrhages and bleeding that previously would have been judged to be catastrophic or fatal for hemophilic patients were rapidly brought under effective control.

The second discovery utilized the low solubility of the clotting protein at freezing temperatures, which was first observed in the 1950's. Judith Pool and associates of Stanford University in 1964 found that the precipitate that remains undissolved when frozen plasma is thawed slowly at icebox temperatures can be used to stop bleeding in hemophiliacs. The scientists developed a procedure by which blood banks can collect this material in concentrated form, called cryoprecipitate. This material has largely replaced fresh frozen plasma, and since 1966 has provided the primary mode for treating hemophilia. However, cryoprecipitates as made in blood banks have some disadvantages: their preparation is time consuming and their potency, which varies greatly between units, cannot be determined easily.

The latest developments are generation III or

A boy with hemophilia receives antihemophilic concentrates, a recently developed material used to prevent as well as treat the massive bleeding episodes characteristic of this disease.



high-potency concentrates made by combining several procedures used in preparing various generation II concentrates. The main advantages of the generation III concentrates are that their potency is high and their exact strength is known. High potency means that only a small volume of fluid is needed for treatment and it can be administered simply by syringe. The known high potency of each vial gives this concentrate a particular advantage over cryoprecipitates. At present, however, the supply of the generation III concentrates is small and the only one generally available is the one we introduced in 1968.[7]

Because exact bio-engineering for the control of hemophilic bleeding has become a reality with the generation III concentrates, a medical team can bring patient's clotting ability to normal in a matter of minutes. With the use of the concentrate, major surgery can be carried out on a hemophiliac without bleeding. In contrast to the preconcentrate days when simple tooth extraction was a major medical and dental procedure for a hemophiliac, today full mouth extractions in a hemophiliac are carried out with no excess bleeding.

Concentrates for hemophilia B became available in this country in 1969. The general problems with bio-assay, isolation of the hemophilia B protein, and translation of scientific findings to a practical therapeutic product paralleled those encountered in developing concentrates for hemophilia A. In certain respects, however, the work with hemophilia B concentrates was somewhat easier because the material is more stable.

A fuller description of the advances in the treatment of hemophilia can be found in the book "Hemophilia and New Hemorrhagic States," which was written by scientists and physicians who have been significantly involved.[9]

It would be a boon indeed if the clotting mechanism of persons with hemophilia could be permanently normalized. One way to accomplish this might be by transplanting from a donor the organ responsible for the manufacture of the antihemophilic protein. But what organ to transplant? Many attempts to identify the organ that produces the antihemophilia A factor have been unsuccessful.

Early studies from our laboratory pointed to the spleen. But in most laboratories in which spleen transplants have been carried out in hemophilic dogs, this procedure did not succeed in correcting the bleeding tendency for more than a few days. This failure may have been due in part to the dogs' rejection of transplanted spleens. However, the experiments suggest that the spleen is a storage depot for the antihemophilic factor rather than the manufacturing site. Our studies then shifted to the kidneys and the liver. Hemophilic dogs seem to have been cured of their disease following liver transplants, but they have lived for only a few weeks or months after the operation. Although research is continuing, transplantation appears to be a long way from becoming an available therapeutic tool for permanently correcting hemophilic defects in humans.

Strategy for the future

With the many advances reported here, it might seem that the problem of hemophilia is well under control. Actually, this is far from the case. Concentrates have improved the lives of hemophiliacs inestimably. But the hemophiliac still requires treatment and close medical attention throughout life.

Use of concentrates in the prevention of hemorrhage appears to be the best approach to the disease, because it eliminates the cost of hospitalization and assures the hemophiliac that he is under hemostatic control. To be most effective, injections with cryoprecipitate are needed daily; injections with high potency concentrates are needed several times a week. Most of the antihemophilic concentrate used today is prepared individually in blood banks. Although 5 to 10 percent of the resources of all blood banks in the country are channeled into the management of this relatively rare condition, the supplies of concentrates—especially those used to treat hemophilia A—currently are inadequate for a preventive program for the entire hemophilic population. Because of the shortage of concentrates, hospitalization will continue to be a common experience for the hemophilic child faced with a severe hemorrhage.

We need to find more effective methods of preparing the antihemophilic factor and to obtain a substitute for the scarce human product. Although animal materials have been produced in the laboratory, they are not in widespread use because they cause hypersensitivity and adverse protein reactions in human recipients.

Prompt transfusion at the first indication of hemorrhage is still vital in treating a hemophilic child. With the increased availability of blood products, transfusions can be done in the doctor's office, the outpatient department of a hospital, or in the patient's home if a member of the family has been trained in the transfusion procedure.

Organization of medical care for the hemophiliac

has improved greatly as new discoveries have been made. About 50 specialized hemophilia centers have recently been developed in hospitals in the United States for the care of patients with serious hemorrhages, surgery, management of the complications of hemophilia, and attention to social problems. Multidisciplinary teams—including hematologists, clinical pathologists, orthopedic surgeons, psychiatrists, dentists, social workers, physical therapists, and other specialists—provide diagnosis, continuing comprehensive care, and rehabilitation. The hope for the future is that by prophylaxis and prompt and adequate treatment for each bleeding episode, serious and crippling hemorrhages will occur less and less frequently, and the need for the hemophilic child to travel repeatedly to specialized centers will be greatly reduced.

Hemophiliacs need improved health insurance. Obviously individual families cannot bear the tremendous financial burden brought on by hemophilia, which might well be classed with the "dread diseases." Under a means test based on the costs for treatment of a child with severe hemophilia A, most families in America would be considered medically indigent.

Some State crippled children's services provide treatment for children with hemophilia, but most of them do not have enough money to pay the full cost for families who cannot pay anything or even to make up the difference for families who can pay part of the cost. The same is true of Medicaid. Obviously, attention needs to be given to the special problem of the hemophiliac when methods are revised for the delivery of and payment for medical care of the chronically ill.

Family planning services and information are needed for families with a history of hemophilia. When families become aware of the many social problems related to hemophilia, they are more likely to consider therapeutic abortion as an alternative to the birth of a hemophilic son. Even so, the large number of mutations and the skipping of generations in the appearance of the disease make the elimination of hemophilia in future generations unlikely. Realistically, the goal of the National Hemophilic Foundation, public health and rehabilitation workers, and other persons interested in hemophilia is to reduce the birth rate among affected persons to the greatest extent possible.

While many problems exist for the hemophiliac today, the tremendous advances in the past 20 years should not be overlooked. Crippling has decreased, the need for hospitalization has decreased with modern treatments, and large numbers of hemophiliacs are growing up to become well-adjusted, contributing members of society. These advances are the direct result of laboratory, animal, and clinical research. The struggle of man to uncover Nature's secrets continues. Successes on the research front will be reflected in continued improvement in the treatment of the victims of hemophilia.

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Why can't the doctors, nurses, parents, treat kids more like humans? Don't they think we don't know or will understand? Why can't they explain? . . . When a kid is 10 to 15 he ought to know the score of the show if he is one of the characters. . . .

A young hemophiliac as quoted by Alfred H. Katz in "Hemophilia: A Study in Hope and Reality." Charles C Thomas, Springfield, Ill., 1970.

FOSTER FAMILY SERVICES FOR MENTALLY RETARDED CHILDREN

BEATRICE L. GARRETT

A year ago the President's Committee on Mental Retardation issued a report that challenges community planners, persons in the helping professions, and lay citizens alike to develop a more adequate range of resources for mentally retarded children than presently exists. Such a range of services the committee saw as necessary for achieving the "programing goals" of integrating the child into normal community living and enabling him "to develop his ability and potential to the fullest possible extent . . ." [1]

The most important resource for achieving such goals are services to enable mentally retarded children to develop within their own families. However, some children cannot be cared for at home, and for them a major resource is foster family care.

Foster family service can provide the child with an opportunity to become a part of the community. It can also provide him the kind of individual, loving attention that in many cases has helped mentally retarded children realize unsuspected potential.[2] Whether a child who cannot be kept at home is placed in foster family care or an alternative resource must, of course, be based on the individual needs of the child and his family. Experience has shown, however, that most children, especially younger children, thrive better in a family setting, provided the family has an understanding of their needs and how to meet these needs.

Foster family care is distinguished from group care and institutional care by its smaller size (six or fewer children in the home unless they are all siblings), by being community based, by age differences in the children, and by the family living pattern. In States that require foster families to meet standards for licensing, the use of overcrowded foster homes—or what amounts to small institutions labeled as foster homes—can be avoided.

Used appropriately, foster family service often results in more progress and less misery for the mentally retarded child. It may also save money, but how much can desirably be saved is questionable. One study has indicated that foster family placement of 24 children saved a State $200,000 in one year.[3] The question is, however, whether the program *should* have saved that much money. Were the foster families not sufficiently reimbursed or the children's special needs not met?

Because of the many advantages of foster care for children who must be away from their parents, many institutions and child welfare agencies today are attempting to increase and improve foster family

services for mentally retarded children. In doing so they are often confronted with many difficult problems.

Concepts for programing

The President's Committee on Mental Retardation has identified two concepts for working with the mentally retarded that can be valuable as guides in evaluating, improving, and developing foster family service for mentally retarded children. These concepts have been called "normalization" and "human management." [4]

Normalization refers to designing programs for mentally retarded children so that they will—

1. Enable the child to behave in a way that will lead others to perceive him as not too different from other children—or at least as little different as possible.

2. Help others see the child's strengths and similarities to other children so that his differences from others will be minimized.

3. Help people in general gain a broader perspective of what is normal and acceptable in child development.

Four interrelated and inseparable principles, derived from the normalization concept, apply to foster family service:

- *Integration*—promoting opportunities for the child to interact with others in the community. This goal can best be achieved for the child who can adjust outside of a group situation when he lives in a normal community with a family that uses the community's resources in the usual ways.

- *Dispersal*—placing no more foster children in each community than can be absorbed and integrated into community life.

- *Specialization*—developing a team of social caseworkers, mental retardation specialists, and foster parents with knowledge and skill in fostering the potentials of children who have problems of development and acceptability.

- *Continuity*—ensuring the continuing involvement of the child's own family in his life through opportunities for interplay between the parents and the child as long as this is useful for the child.

The human management concept applies to the parents of the mentally retarded child as well as to the child himself. It has three main requirements:

- That the child's parents be regarded by the helping staff as normal persons under unusual stress, and not be "denormalized" by being regarded as different from other parents.

- That, with rare exceptions, the foster family be used only to supplement and not supplant the role of the child's own family. Next in importance to maintenance of life for the child is maintenance of his place within his family.

- That decisions regarding structure, policy, and individual problems be measured by whether they best meet the individual needs of the parents and child, not by whether they promote medical, institutional, or program "efficiency."

Provision of service

Today foster family services for mentally retarded children are provided under various auspices—specialized institutions, State and local child welfare agencies, voluntary child welfare agencies, and different combinations of these. In a recent study of intake of public and voluntary child welfare services in seven cities, 5.2 percent of the children served had IQ's below 75. Seventy-nine percent of these children were served by public agencies.[5]

If medical, psychiatric, psychological, or other specialized services the child needs are available for diagnosis and treatment, the retarded child is usually better served through the existing community-based child welfare agency than through an institution or clinic far from his home. The community-based agency that has a comprehensive service for children and their families can help parents decide whether they can keep the child at home or whether the child should be placed in an institution in another community or in a nearby group home or foster home.

An agency can improve its services to mentally retarded children by assigning a staff worker as an ombudsman (or advocate) for such children. The ombudsman will consistently hold the agency to its commitment to meet these children's needs.

Regardless of whether the service to mentally retarded children is provided through a community-based agency or an institution that develops a foster family service, the quality of the service is dependent on clearly spelled-out plans for coordination with

other resources. The expertise, knowledge, and resources of both the institution or agency specializing in service to the retarded and the agency specializing in foster family services are required. For instance, a State institution for mentally retarded children may, after an interagency planning conference, enter into a written agreement with a county child welfare agency to provide diagnostic evaluations for a mentally retarded child while the county agency works with the parents and provides foster family services.

Coordination between community resources is also important for staff training. The concepts, knowledge, and skill that social workers have developed to help other children and their families are, of course, basic to foster family service to the mentally retarded. But work with the retarded requires additional knowledge about the meaning of mental retardation to children and their families as well as special skill in dealing with their problems. Agencies need to plan ways of helping their workers achieve the necessary knowledge and skill. The specialized institution or clinic may be the best resource for teaching social workers the unique aspects of such work. Child-caring agencies sometimes arrange for an exchange of workers to achieve such training. Some agencies also assign all cases involving mental retardation to workers who handle only this type of case and who thus have an opportunity to sharpen their insight and skill in helping the mentally retarded.

Indications for use

Foster family care has several advantages over institutional care for a child, especially one whose retardation stems from emotional deprivation or lack of stimulation rather than from organic causes, for such functional retardates are likely to thrive in a normal family environment: (1) it does not set the child apart; (2) it provides social, emotional, and developmental experiences through close, continuing relationships with parent substitutes; (3) it provides a greater chance for development along socially normal lines through day-to-day interaction within a family and community; and (4) when the child is placed in his home community, it makes it easier for the members of his own family to keep in touch with him. Placing the child near his own home is especially important when the plan calls for his eventual return to his family.

Foster family care is not suitable for the child who, because of severe behavior disturbances, may be dangerous to himself or others when not in a controlled environment. Children who require specialized medical treatment not available in the community may also need institutionalization. Some institutions have developed satellite foster family programs so that children can have the advantages both of family life and specialized medical care.[6]

Retarded children may be placed with foster families for various reasons: (1) to give parents time to deal with the psychological impact of learning of their child's retardation and to come to a considered decision about care of the child; (2) to give a family temporary respite from the strain of caring for the child; (3) to learn through observation whether the child has hidden potentials; (4) to provide the child with a family experience preliminary to eventual institutionalization; and (5) to provide part-time care (for example, 5 days a week) or care during the family's vacation.

To be of real value for a child, foster family placement should be selected specifically to meet the child's needs. It should not be just a holding action to serve until institutional space becomes available. Careful selection of the right home, continuing supervision of the child, and support for the foster family tend to prevent the harmful experience of replacement. Placement is effected preferably through a voluntary agreement signed by the parents, but in many instances it results from a temporary or permanent court commitment.

Work with parents

Foster family service has four main components: the provision of social service for the child's own parent; the provision of social service to the child; recruitment, supervision, and education of the foster families; and development of cooperative working arrangements with community resources.

Parents of mentally retarded children needing foster family service come from all socioeconomic levels. The service to parents begins when the possibility of placement is first brought to the agency's

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attention, whether directly by the parents or through a referral from an individual, a court, or another agency. The service is focused on helping the parents make and follow through with the kind of decision that is most likely to be helpful to their child and one which they can live with comfortably. In helping parents come to a decision, the medical practice of using the least drastic treatment applies. This leads to the following order of priorities for consideration: (1) maintenance of the child in his own home; (2) placement in an adoptive home; (3) placement in a foster family; (4) placement in a group home; (5) placement in an institution.

The decision on treatment is most appropriately made on the basis of careful multidisciplinary study and diagnosis of the specific persons involved and the specific situation, rather than on a general statement of priorities or rules and regulations. For example, consider a 5-year-old child whose mother will never be able to make a home for her because of a chronic illness. The accepted priority would be to plan adoption for the child, but the social study establishes the fact that there are strong ties between mother and child. Therefore, the decision is to place the child in a permanent foster family and arrange for regular visiting between mother and child.

Parents have a right to service both as persons in need of help and as parents of a mentally retarded child. All parents who are considering placing their child away from home are experiencing a crisis in their lives. However, parents of a mentally retarded child must deal with a crisis of special severity. In recognizing their child's retardation, they have sustained an agonizing blow to the ego. They are often torn by ambivalence and are dreadfully confused. They cannot help but feel depressed and devaluated. They may feel guilty. Their defense may lead to rigid denial and "shopping around," to masochistic commitment to the child, or to complete inability to cope.

Such parents need a reliable relationship with someone who is competent to help them, who can give them—whenever they feel the need—personal acceptance, warmth, emotional support, information, guidance, and practical methods for dealing with their problems. They need continuing help in working through their grief before, during, and after the child is placed. A social worker can provide this service through one-to-one conferences, interviews with the whole family, group meetings for education or treatment, and referral to other resources.

The social worker must be alert to the often contradictory feelings of parents in order to help them arrive at a sense of security in their decisions and decide how they can handle the spoken and unspoken questions of their other children, neighbors, and relatives.[7]

The development of a careful social diagnosis, tentative prognosis, and recommended treatment, and provision of supportive services are the work of a multidisciplinary team. Beside the social worker, this team may include pediatricians, psychiatrists, psychologists, child development specialists, nurses, speech therapists, nutritionists, physical therapists, and others. To secure the services of such a variety of disciplines, many agencies have to depend on special clinics and institutional staff.

When the time is right, the social worker uses the team's recommendations, as well as its findings concerning both feeling and tangible facts to involve the parents in weighing alternatives. The parents need time in making their peace with the chronic problem facing them. After the initial crisis that brought them to the agency, they need to feel that an agency, preferably the same one that made the placement, is available to help them when new problems arise.

Many parents are more able to accept institutional care than foster family care. They and their neighbors see the institution as a medical facility that provides special services not available to them at home. They can more easily justify this to themselves and others than they can justify placing their child with a family unrelated to them.

The child

Mentally retarded children for whom foster family care is considered vary greatly. They may be in early infancy or in late adolescence; passive in temperament or hyperactive and hostile; in good physical condition or handicapped by complicated physical defects or medical problems. Their retardation may be regarded as profound, severe, moderate, or borderline. They may look strange or be normal in appearance. In many children the retardation may stem from deprivation rather than organic impairment.

In all mentally retarded children there are both similarities to, and differences from, other children. In many of these children the differences result in problems that place extra demands on community resources, on parents, and on foster parents. These problems require different degrees of care and service, ranging from total physical care to specialized vocational training.

Of significance in foster family placement is the likelihood that the mentally retarded child will be slower than other children to adjust to new people and new places. He needs more preplacement preparation—more retelling of the what and why of placement, and more preplacement visits to the foster family's home. If at all possible, he should be accompanied by his parents on the preplacement visits and at the time of placement. If the child is living in an institution, he may need to be visited by the foster parents several times and then to be taken home with them for a number of overnight stays before being placed in their home.

In working with the foster parents, the social worker can use the child's reactions to the preplacement visits to help the child express his feelings and to answer his spoken and unspoken questions. How the parents, the caseworkers, and the foster parents handle the actual placement and the child's feeling of loss at being separated from his parents will greatly affect the child's future sense of identity.

For example, the child whose sense of time is limited and who has difficulty in understanding where his parents are if they are not present, may lose all conception of who he belongs to unless the verbal explanation is reinforced by visits.[8]

Mentally retarded children have certain characteristics in different degrees, for which foster parents need preparation and continuing help. These include: lack of interest in the environment, lack of affectionate response, slowness to learn, inability to communicate feelings or relieve anxiety through verbal expression, rocking and head banging, repetitive behavior, pica, resistance to change, resistance to routine and habit training, slow development of independence and self-help, flightiness or short attention span, hyperactivity, unevenness in ability, memory problems, and apparent immunity to pain. Such characteristics are often sources of frustration and confusion for foster parents.

Foster parenting

Foster parents of mentally retarded children need the same qualities as foster parents of other children, but they need some of these qualities in an unusual degree. All foster parents need to be in basic marital agreement and to have physical and emotional stamina, the ability to love the child as he is, and the ability to work with the agency and to grow in their vocation. But foster parents of mentally retarded children need some qualities in an unusual degree—

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patience, confidence, readiness to set up expectations that are tailored to fit the child's individual needs, optimism and an ability to receive satisfaction from small gains, to tolerate frustration and "endless" repetition and to allow the child to be dependent as long as needed without losing sight of ways to help him grow toward self-dependence. They also need a secure feeling of acceptance by their neighbors and by others who are important to them.

The agency can support foster parents through one-to-one supervision and through educational group meetings at which various types of specialists in mental retardation can help them achieve greater understanding and skill in working with the child. The agency can also help foster parents recognize and deal with the child's feelings and capacities; know how much to expect from the child; use toys to encourage motor activities; and help the child understand feelings aroused by objects and people and prepare him for things to come.

The agency may also help foster parents examine their own feelings about the child's own parents and recognize the child's need to express his feeling of loss and separation from his family;[9] learn how to help the child develop a self-image through the use of everyday devices, such as mirrors and pictures; set up and consistently enforce a few rules and routines in accordance with the child's needs; and find ways for the child to do some things successfully, praising him for his effort as well as for his successes.[10] But even more important than developing those techniques, foster parents need to know how to help the child feel loved, enjoyed, and valued.

Of great importance in foster family service is the availability of the special resources the child may need at different stages in his development. What about medical facilities offering expertise in problems of mental retardation? Do the schools provide suitable instruction for mentally retarded children with a minimum of separation from other children? Are there facilities for vocational training and a sheltered workshop for the teenage youth? Are there

camps, day camps, "Y's" and other recreation facilities that make provision for these children? Is there a day-care center or nursery school that may be used to stimulate the child and to give relief to the foster parents? What is the neighborhood attitude likely to be toward the child who has a different way of developing? Can the foster parents be helped to handle negative reactions and teach neighborhood children to play with the child? Foster parents need to know about such resources and how to use them.

The process of recruiting and selecting foster parents for mentally retarded children begins the preparation for the important job of foster care. It is a teaching process that must continue on a planned basis throughout the period of service.

If mentally retarded children are to be provided with foster care, the community needs to know about their need for foster parents. This requires a year round recruitment program presented in a down-to-earth way that points up the contribution foster parents can make without glossing over the difficulties of caring for a mentally retarded child.

In spite of the difficulties, foster parents can be found for children of all levels of retardation. For example, of 36 foster parents interested in caring for retarded children, 44 percent said the level of retardation did not matter to them; 25 percent said their interest stemmed from previous close contact with a mentally retarded person; and 25 percent said they had accepted retarded children because they were asked to meet a pressing need. Fifty percent said fostering of mentally retarded children was a job for which they should be paid.[11]

Many more foster parents are likely to become available and to continue in service when agencies institute certain modern administrative practices for all but permanent foster families. These practices include: full reimbursement for the actual costs of keeping the child; provision when needed of agency-owned or rented houses, in some instances especially equipped for children with handicaps; regular relief help; homemaker service; and a reasonable salary for the foster parents plus the same fringe benefits available to other agency employees.

Some propositions

In summary, I present the following propositions arising from the concepts of normalization and human management for consideration by persons who have a responsibility to plan for or serve mentally retarded children:

1. When a child cannot be cared for at home or placed for adoption, foster family service should be the preferred method of care unless the child obviously requires another form of care.

2. At the time the child is diagnosed as being mentally retarded, especially a child from a disorganized family, the diagnosis should be tested by providing him with an emotionally enriching and stimulating family and community living experience.

3. A community-based comprehensive child welfare service is the best means for providing a foster family service for mentally retarded children *if* it accepts this responsibility and makes administrative provision for such a program.

4. Foster family service for mentally retarded children of all socioeconomic levels, as for other children, must include counseling for the child's parents as well as service for the child.

5. The foster parents should be employed by the child-serving agency, be paid a reasonable salary with fringe benefits in addition to the costs of foster care, and be provided with sequential educational opportunities for increasing their competence in serving the child.

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an essay review

THE CONCERN OF ONE GENERATION FOR THE NEXT

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History has given us a number of reports of cultures in which children have been reared to become ideal citizens of the State. Plutarch, for example, described how Lycergus dictated the communal living of young Spartan boys to foster the development of attachment and loyalty to each other so that he might have a magnificent army. In his book "Two Worlds of Childhood,"* Urie Bronfenbrenner has become a modern Plutarch by analyzing his brilliant studies of child-rearing patterns in the U.S.S.R. In contrast to Sparta, in the Soviet Union there is obviously not only a concern for children themselves, but also a major investment of resources, manpower, and community interest in rearing the healthiest and best functioning children possible. As one Russian authority has explained, "It is not true that we have a classless society. Children are our privileged class."[1]

In contrast to the other mammals, the human young when they complete the first round in personality development—which they do chiefly within the family—are still not ready physically or mentally to take a place in the adult world. Instead, they then go through what Benjamin Spock has called a "middle-age period of childhood." In this period the child learns, through group participation and exploration, about the characteristics of the segment of the world around him, its makeup, patterns, expectations, rules, and value systems.

Bronfenbrenner, who has studied the Soviet school system and child more intensively than any other "outside" scientist, details how the Russian school program uses this developmental pattern of group formation to guide character formation, emphasizing loyalty to the group above the individual and stressing group achievement and enforcement of correct behavior. His thesis is that in the United States the lack of a comparable systematic approach has led to increasing problems in our educational institutions and communities.

Different approaches

Actually the pictures cannot be so definitely contrasted. Both systems (if the American pattern can be called a system) have their successes and their failures. However, the Soviet approach unquestionably prevents most of the culturally determined mental retardation seen in this country. It creates the climate for and expectation of community involvement, responsibility, and participation. It also seems to have resulted in less juvenile delinquency, although there are recent reports of increasing delinquency in the U.S.S.R.

One cannot argue with the underlying Soviet concept that the teacher of the young is one of the most valued contributors to the good of the country and should be selected, trained, and paid accordingly. However, the American goals for the ideal individual citizen are quite different from the Russian, emphasizing as they do self-reliance, independence, and self-sufficiency, as well as patriotism and team spirit. What is missing in the American approach is the dedication and the resources poured into the "upbringing" process that one sees in the U.S.S.R. It is estimated that in 1967 our Federal Government spent $190 per child in contrast to close to $2,000 per older citizen, even though there is increasing evidence that much of the health and adjustment of later life has its roots in appropriate health care and experience in early childhood. Our expenses for the elderly are too late for righting many of the deficits created by neglect and disregard in the first 3 to 5 years of life.

There is a slow but growing awareness around the world about the importance of appropriate care and experience in the first years of life to the individual's later development. Recognizing this fact, the Soviets for a while began providing a group living experience in infancy in an attempt to make optimal development possible for all children. Bronfenbrenner points out that the Soviets then found that family experience is of crucial importance and that there is no real substitute for the basic mother-infant closeness and affective interaction and so modified their practice.

However, the U.S.S.R. is asking itself a question the rest of the world must consider: "Is there not so much for the developing human to learn and be prepared for in an increasingly technologically oriented universe that we can no longer leave early experience only to

*TWO WORLDS OF CHILDHOOD. Urie Bronfenbrenner. Russell Sage Foundation, New York, N.Y. 10017. 1970. 185 pp. $7.95.

the family, but, long before the child reaches school age, must add group education and experience to what the family provides?" The Soviet's answer is the provision of "infant upbringers" for a network of infant schools. These "upbringers" are usually well trained and highly regarded as representatives of a new professional type of community resource.

Soviet psychology and psychiatry have placed major stress on the influence of the environment on behavior and character development. This emphasis underplays, or even discounts, individual differences in constitutional makeup, in the belief that desirable molding can be accomplished by appropriate training and early group experience. This point of view has its Western counterpart in the recent preoccupation with behavior shaping through "operant conditioning."

A serious omission

These approaches to child-rearing and learning disregard the "inner life" of the child, a component which is beginning to be acknowledged and considered in the U.S.S.R.[2] Bronfenbrenner takes cognizance of the importance of this component only as he describes the warmth and intensity of the Russians' early mother-child relationships as a necessary precursor of the child's ability to be effectively attached to a group. But from there on he gives the child's inner life little consideration as he describes the influences of such forces as social reinforcement and modeling or shaping the behavior and moral responses of the individual child through appropriate guidance of group pressures and group responsibility. He reveals a possible new trend, however, by quoting Novikova, the Soviet child development authority: "We have to discover how to create the kind of collective which will insure the most full and many sided development of each person."

What evidence do we have about the eventual outcome of these child-rearing approaches? Precious little, unfortunately. A somewhat facetious and quite unscientific reply was given to President John F. Kennedy by a member of his Panel on Mental Retardation who reported on a committee's investigations of Soviet child-rearing patterns. The President asked, "Does it work any better than ours?" The answer was, "We don't really know, but we did a small research study with young Moscow taxi drivers who are not supposed to take tips. Fifty percent of them do."

What are the goals?

What should be our goals in the development of our children? What should we prepare them for? Must we not think of their readiness to function in relation to the realities of the world around them?

Rapidly, "the world of childhood" is becoming the whole world. The forms of violence as carried out in Asia, Africa, or Chicago are brought by television into every American living room. Are Soviet children better off for not being exposed to instant replays of guerilla warfare or replays of the devastation wrought in Hiroshima?

Are our children fascinated by violence on television because they are attempting to learn how to cope with the violence around them? Are some of them becoming alienated because of the duplicity they see between countries and blocs as well as in their own families' dealings with insurance companies or the income tax? Do we say to them, like the Pirate King to Frederick, "Away to the cheating world go you," or do we help them develop better value systems?

We need to help children develop maximum flexibility and ability to move ahead to new solutions for problems instead of "turning off." This means including the new dimensions of today's world in the horizons of our young and the new tools and devices they need to deal with the world as it is and with each other. Encouraging in children the inner freedom to think and act in new ways is not incompatible with the development of good citizenship, a sense of responsibility, and respect for the integrity, rights, and territory of others.

The end result of the Soviet group child-rearing patterns and the American middle-class patterns are similar as far as the parents are concerned. When the school-age child is "turned over" to the peer group, the parents are freer to use their day and leisure time for other purposes. Bronfenbrenner points out the major difference—the Soviet children have much more intensive, guiding supervision from trained and interested adults and more involvement with groups of children older than themselves. He plugs for more supervision and adult involvement with school-age children in the United States than simply the parents' attendance at PTA meetings.

Most of the action Bronfenbrenner proposes centers on the disadvantaged child. With this we obviously can have no quarrel. In fact, we can agree with all his recommendations while disagreeing with his reasons for some of them. For example: Isn't the violence that the slum child sees around himself everyday more influential than the violence he sees on TV? Couldn't the aggressive response of the middle-class child to violence in TV, shown in Bandura's experiments—referred to by Bronfenbrenner—be explained by the well known mental mechanism of "identification with the aggressor?" I am not, of course, recommending overdoses of violence anywhere in the child's life experience.

In the United States we need to give an overriding priority to seeing that the needs of every child for developing properly are known to responsible persons and that the means of meeting these needs are made available, as they are in the U.S.S.R. The concept of a Community Commission on Children, suggested by Bronfenbrenner, would be one means of accomplishing this objective as would the similar child advocacy program recommended by the Joint Commission on the Mental Health of Children.[3] The principle to be guided by is provided by Bronfenbrenner in his statement of his theme, ***the concern of one generation for the next.***

In the United States we are concerned, but we are not always aware of what to be concerned about until the child, the family, or the community is hurting. Urie Bronfenbrenner, the roving Professor of Child Development and Family Studies from Cornell, has given us some valuable guidelines.

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BOOK NOTES

DISTURBED CHILDREN: examination and assessment through team process. Staff of the Menninger Clinic Children's Division, The Menninger Foundation. Jossey-Bass, Inc., Publishers, San Francisco, Calif. 1969. 296 pp. $9.50.

In this book, staff members of the Menninger Clinic at Topeka, Kans., describe the interlocking methods they have devised for working as a team in reaching a psychiatric diagnosis for disturbed children brought to the outpatient department. The basic team includes a psychiatrist, a psychologist, a social worker, a neurologist, and a speech and hearing therapist; other specialists are added when necessary.

According to the authors, the psychiatric diagnosis of a child must involve consideration of congenital, gestational, maturational, physiological, neurological, psychological, parental, familial, cultural, religious, and socioeconomic factors. Each member of the team contributes to the development of an integrated, comprehensive diagnosis on which treatment is planned. Parent participation in each step, which is an integral part of the Menninger method, enables the family to understand and accept the diagnosis.

The book includes many case illustrations of the points made in its chapters on the team process in diagnosis; working with parents; evaluation of treatability; the psychologist's contribution; speech, language, and hearing; the neurological examination; the psychiatric examination; the role of conferences; team function and misfunction.

THE WRITINGS OF ANNA FREUD. Volume V: research at the Hamstead Child-Therapy Clinic and other papers, 1956–1965. International Universities Press, Inc., New York, N.Y. 1969. 575 pp. $12.

Volume V in this series of Dr. Freud's works on psychoanalytic theory in relation to child development contains a number of short papers on such subjects as adolescence, emotional and social development of young children, children in the hospital, family law, and the contribution of direct child observation to psychoanalysis. A number of the papers are published for the first time, including "Psychoanalytic Knowledge and its Application to Children's Services," "The Contribution of Direct Child Observation to Psychoanalysis," and "Psychoanalytic Knowledge Applied to the Rearing of Children."

Among the previously published papers that appear in this volume are "The Theory of Parent-Infant Relationship," "Children in the Hospital," and "Entrance into the Nursery School: the Psychological Prerequisites." The volume also includes outlines of applications submitted to foundations to obtain financial support for research, and introductions written by Dr. Freud for books by her colleagues at the Hamstead Clinic.

A FOLLOW-UP STUDY OF ADOPTIONS: post-placement functioning of adoption families, vol. I. Elizabeth A. Lawder; Katherine D. Lower; Roberta G. Andrews; Edmund A. Sherman; and John G. Hill. 1969.

POST-PLACEMENT FUNCTION OF ADOPTED CHILDREN, vol. II. Janet L. Hoopes; Edmund A. Sherman; Elizabeth A. Lawder; Roberta G. Andrews; and Katherine D. Lower, 1970. Child Welfare League of America, Inc., New York, N.Y. $4 each.

These two publications present the results of a research project carried out jointly by the Bryn Mawr College Graduate Department of Social Work and Social Research and the Children's Aid Society of Pennsylvania, with support from the Children's Bureau.

The first volume reports on attempts to answer two main questions: how adequately do adoptive couples adjust to the responsibilities of adoptive parenthood and what information predictive of later family functioning can be obtained before completion of adoption. The second volume reports on an attempt to discover in what ways the adopted child differs from the child reared in his own home and to identify factors predictive of adoption outcome.

The findings reported in volume I were based on questionnaires and personal interviews with 200 families, selected at random from the 556 families in which children had been placed by the agency from 1950 through 1957. The investigators found that at least 70 percent of the parents functioned "average" to "high" on all areas rated except "communication of the fact of adoption."

The most important aspects of family functioning turned out to be degree of parental warmth and affection, satisfaction in the adoption and parental role, and role compatibility in decision-making; a positive predictive factor, the parents' ability to discuss their feelings about infertility during the application process; and a negative predictive factor, excessive criticism of the child by the parents during the supervisory period. Differences in the children were found to be less important to family functioning than the parental factors of warmth and acceptance of adoptive role.

Volume II reports on the development of 100 adopted children, ages 10–15, selected at random from the pool of families previously studied. They were matched for sex, school grade, and social class with 100 children living with their own parents, and compared in relation to intelligence, teachers' ratings on overall school adjustment, and personality, measured by both objective and projective tests. The findings showed no difference between the two groups in intelligence or in personality measures. On teachers' ratings of overall adjustment, 55 percent of the adopted children were rated as "good to excellent," but more control than experimental children were rated as "excellent."

An analysis of the case records showed the capacity of the father to accept infertility bore a relation to his acceptance of the child. The parents' age at time of application was unrelated to the child's later functioning as was their ease of communicating the

fact of adoption to the child. Again parental warmth and parental role compatability in decisionmaking outweighed negative factors concerning the child, including the previous deprivation.

The authors point out that the research population was Caucasian, predominantly Protestant and middle to upper-middle class and that their findings do not necessarily apply to a differently composed population or to independently adopted children.

HEMOPHILIA: a study in hope and reality. Alfred H. Katz. Charles C Thomas, Publisher, Springfield, Ill. 1970. 159 pp. $9.

This book examines the social, psychological, medical, and employment problems of persons with hemophilia, an inherited male disorder in blood clotting that is marked by episodes of uncontrolled bleeding (see p. 222). After identifying the "key" problem for the parents of a hemophilic child as that of providing necessary physical protection without overprotection, the author warns that too many restrictions can lead to psychological crippling. He cites a survey of adult hemophiliacs, who said they would advise parents to let a hemophilic son live as nearly a normal active life as he could.

Pointing out that the hemophilic child has frequent and prolonged absences from school because of hospitalization or episodes of bleeding that keep him at home, the author suggests steps a local school board can take to meet the special educational needs of hemophiliacs and other chronically ill children. He reports that a relatively large proportion of hemophiliacs have inadequate educations: in a survey of 1,055 men who had the disease, he found that 34 percent had not completed high school.

The author declares that society's lack of knowledge about, and understanding of, hemophiliacs is a basic social problem. In addition to a communications program designed to increase the public's general understanding of the disease and to present a more realistic picture of the hemophiliac, the author recommends reevaluation and extension of rehabilitation efforts, vocational counseling, early detection of adjustment problems followed by appropriate action, parental counseling, counseling of the hemophiliac on problems of life adjustment, genetic counseling, disability insurance, and preplanned hospital care.

The author teaches in the schools of public health and social welfare, University of California, Los Angeles.

guides and reports

DEVELOPING MENTALLY HEALTHY CHILDREN. Katherine E. D'Evelyn. Introduction by Reginald S. Lourie. American Association of Elementary - Kindergarten - Nursery Educators, 1201 16th Street, NW., Washington, D.C. 20036. 1970. 32 pp. $1.25.

Describes what is necessary in an elementary school to promote the mental health of children.

CHILD WELFARE AND THE COMPUTER: a projection of potential. Dr. Brandt R. Allen and Dr. Alexander B. Horniman. Edwin Gould Foundation for Children, New York, N.Y. 1969. 35 pp. No charge.

Presents a model for computerizing information in the child welfare field.

ETHNIC MINORITIES IN SOCIAL WORK EDUCATION. Edited by Carl Scott. Council on Social Work Education, 345 East 46th Street, New York, N.Y. 10017. 1970. 89 pp. $3.

Contains 10 papers that discuss ways of bringing more students from minority groups into schools of social work and reorganizing the social work curriculum to deal with the problems of racism, poverty, and inequality in America.

HELPING LOW-INCOME HOMEMAKERS: programs and evaluations—a selected, annotated bibliography. Margaret Harding. New York State College of Human Ecology, Cornell University, Ithaca, N.Y. 14850. 1969. 142 pp. $2.50.

Contains digests of 208 reports chosen for their interest to home economists, agricultural extension agents, social workers, and other persons who work with low-income families.

INSURANCE PROGRAMS FOR NEIGHBORHOOD CENTERS: a guide. National Federation of Neighborhood Centers, 232 Madison Avenue, New York, N.Y. 10016. 1970. 20 pp. $1.

Recommends and analyzes various types of insurance coverage for use in neighborhood centers in relation to employee benefits, property damage, liability, crime, and other coverage.

HIGH SCHOOL STUDENTS AND DRUGS: the report of a national seminar. Institute for Development of Educational Activities, Inc., Information and Services Division, Box 446, Melbourne, Fla. 32901. 1970. 20 pp. $1.

Discusses drug use and suggests educational programs for teenagers.

DRUGS ARE STILL NOT THE PROBLEM . . . BUT . . . Seymour S. Cohen. B'nai B'rith Youth Organization, 1640 Rhode Island Avenue, NW., Washington, D.C. 20036. 1970. 8 pp. 10 cents.

Suggests ways of reversing the current "fad" of drug use among teenagers.

A PARENTS' PROGRAM IN A SCHOOL FOR THE DEAF. Paul Rotter. The Lexington School for the Deaf Education Series, Book VI. Alexander Graham Bell Association for the Deaf, Inc., 1537 35th Street NW., Washington, D.C. 20007. 1969. 114 pp. $4.25.

Describes why and how parents are involved in the educational process in a school for the deaf.

HERE and THERE

Health services

Establishment of community, State, regional, and Federal child health advisory councils to coordinate the provision of health care for economically deprived children from birth to 12 years of age was recommended by participants in a 3-day conference held in Washington, D.C., in mid-September. Initiated and financed by the Office of Child Development and cosponsored by the Office of Education, the conference was designed to develop systems of continuous, comprehensive health services for children served by Parent and Child Centers, Head Start, Follow Through, and Title I of the Elementary and Secondary Education Act of 1965, which provides compensatory educational programs for deprived children. The 35 participants included public health physicians and educators, parents, evaluation specialists, and administrators of local, State, and Federal programs with health components.

Integration of health supervision and nutrition into a comprehensive program designed to promote total development of children from low-income families must be a national priority, the conference participants agreed. Speakers identified a number of deterrents to the provision of optimum health care for children, among them: inadequate manpower in professional and paraprofessional health services, especially in rural areas; inadequate financial support of health and nutrition programs; lack of a national commitment to health care for all children by government and private agencies; and lack of coordination of the four programs with which the conference was specifically concerned.

It was pointed out that only a few communities have all four of the programs. The Office of Child Development administers 36 Parent and Child Centers and 1,800 Head Start programs, and the Office of Education directs Title I programs in 16,400 school districts and 150 Follow Through programs.

At the opening session Richard L. Fairley, acting director of OE's Division of Compensatory Education, said that Title I serves more than 8 million educationally deprived children in a variety of educational, social, cultural, and health programs. He reported on proposals that would require that a portion of Title I funds in each program be used for comprehensive health services, including dental and mental health components, and announced grants totaling $2 million for pilot projects to develop models of community coordination of health programs for children. Edward Zigler, director of OCD, told the conference that Head Start has provided health care to more than 3 million children since 1965. He warned that the quality of health programs for children must not be "watered down" as a result of continuing budget limitations.

Panel and group discussions centered on problems of implementing child development services in Follow Through and Title I programs and ways to link the four programs with existing community health services and other federally supported health services. In rural areas where few such services exist and where physicians are often not available, alternate methods of health care for low-income children must be developed, one panelist asserted.

Panel members described comprehensive school health programs in Tacoma, Wash., Oakland, Calif., and Philadelphia, Pa., that include health education and referral of children for correction of medical problems. One participant reported that the United States is the only major western country without a national school dental health program. Another participant advocated that mental health programs be conducted in the schools, so that they can reach all the children in need of such services, instead of in community mental health clinics, which only reach one of every 14 seriously disturbed children.

Discussion groups reported agreement that parents should participate fully in planning and coordinating health care in local, State, and Federal programs.

The conference also recommended that—

- Health programs be child focused.
- Health programs be mandatory in Title I as well as in Parent and Child Centers, Head Start, and Follow Through, but requirements be as flexible as possible.
- Common evaluation and monitoring systems, procedures, standards, and goals be developed and adopted for the four programs.
- Coordination of health programs be improved at all levels.
- Content of health programs be modeled on Head Start services and be reinforced by drawing on the strengths of the other programs.

Drug use

The use of amphetamine drugs is now limited to three specific medical purposes, under an order issued by the Food and Drug Administration in August to prevent their abuse. In the past, amphetamines have been widely sold as stimulants and appetite suppressants, but the order permits their sale only for uncontrollable sleepiness (narcolepsy), hyperkinetic behavior disorders in children, and short-term treatment of obesity. In issuing the order, the FDA asked manufacturers to reduce their production and sales of amphetamines.

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The National Institute of Mental Health has recently established a National Clearinghouse for Drug Abuse Information. The clearinghouse refers scientific and technical questions about drugs to government and private agencies, stores and retrieves computerized data on drug programs, and distributes government publications and films to parents, students, teachers, law enforcement officers, community leaders, and

others concerned with the drug problem.

Inquiries in any area of drug abuse may be sent to the National Clearinghouse on Drug Abuse Information, Box 1701, Washington, D.C. 20013. A 24-hour-a-day telephone service has been set up; the number with area code is 301–496–7171.

Nutrition

Pregnancy holds greatest risks for girls under 17 years of age who have not completed their own growth, for women in low-income families who have never had adequate diets, for women who restrict their weight gains to less than 15 pounds, and for women who have repeated pregnancies, according to a study by the Committee on Maternal Nutrition of the Food and Nutrition Board, National Research Council, released in July. Supported by the Maternal and Child Health Service (then in the Children's Bureau, but now in the Health Services and Mental Health Administration, HEW), the study of maternal nutrition and the course of pregnancy grew out of concern about the relatively high neonatal and infant mortality rates in the United States.

A long-term aim of public health activities should be to improve the nutritional status of women of childbearing age by beginning long before they reach that age, the committee advises. While it puts major emphasis on a good nutritional start early in life, it also recognizes that many other factors—genetic, biological, social, and psychological—are involved in a favorable outcome of pregnancy.

The committee raises the question of whether weight restriction contributes to the large number of low-birth-weight infants (those born weighing less than 5½ pounds) and the related high perinatal- and infant-mortality rates.

The study was conducted by working groups, which examined the relation of nutrition to fetal growth and development, pregnancy in adolescence, and toxemias of pregnancy. Among the groups' findings:

Fetal growth and development:

• An average gain in weight during pregnancy of 24 pounds is desirable, the acceptable range being from 20 to 25 pounds.

• Weight reduction program and severe caloric restrictions should not be undertaken during pregnancy, even for obese women, because of the possible adverse effects on the fetus' weight and development.

• Women who smoke during pregnancy are more likely to have low-birth-weight infants than comparable nonsmokers.

Pregnancy in adolescence:

• An increasing number of infants are being born to girls 17 years of age and younger.

• Disproportionately more low-birth-weight infants are born to mothers under 15 years of age.

• The mortality rate for infants of mothers under 15 years of age is 58.7 per thousand live births, compared with the U.S. average of 25.1 for all infants.

• Among pregnant girls under 17 years of age the incidence of iron-deficiency anemia, toxemia, premature births, and deaths of infants within 28 days after delivery is higher than among older pregnant women.

Toxemias of pregnancy:

• There is no evidence that caloric restriction, often recommended by physicians to reduce the chances of toxemia, has any effect on its incidence. Similarly, there is no evidence that excessive weight gain during pregnancy causes toxemia.

• The widespread practice of routinely restricting salt intake and at the same time prescribing diuretics is of doubtful value in preventing toxemia and is potentially dangerous.

• Emphasis should be placed on the value of a good diet during pregnancy, particularly for women entering pregnancy with poor nutritional status and poor dietary habits.

Among other recommendations, the committee urges that multidisciplinary research and training centers for studying the biology of human reproduction be established; that food programs for low-income families give special consideration to the physiological needs of infants, children, adolescents, and pregnant women; that community health services increase their nutrition services for mothers and children; that school curricula include basic nutrition information and the encouragement of good dietary habits; and that medical schools emphasize the role of nutrition in health.

The complete report, "Maternal Nutrition and the Course of Pregnancy," is available from the National Research Council, 2101 Constitution Avenue NW., Washington, D.C. 20418. (Price: $7.50) A summary report is available without charge from Maternal and Child Health Service, Room 12A–21, Parklawn Building, 5600 Fishers Lane, Rockville, Md. 20852.

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Monosodium glutamate (MSG) should not be added to foods specifically designed for infants, concludes a committee of the National Academy of Sciences-National Research Council in a report of a study issued in August. While the committee reports that the risk of harm to infants from MSG is extremely small, it notes that the additive does not benefit infants in any way. The committee also reports that it found no evidence of hazard "from the reasonable use of MSG in foods for older children and adults, except for those who are individually sensitive to the substance."

The study was requested by FDA in January 1970 in the wake of questions about the safety of MSG in baby foods. U.S. manufacturers of baby food discontinued the use of MSG in their products in the fall of 1969.

Behavior modification

A system of rewarding emotionally disturbed children for academic progress and socially acceptable behavior in the classroom has proven effective in a pilot program now in its third year in the Great Falls, Mont., public school system. Conducted with a grant from the U.S. Office of Education under title III of the Elementary and Secondary Education Act, the program provides two educational adjustment classrooms for children whose emotional problems are so severe that they no longer can be retained in a regular classroom setting.

Children selected from the program have average or near average intelligence, but are achieving below grade level. The program begins with identification and recording of incidents of their specific modes of negative behavior during a 2-week period. A special curriculum is then devised for each child, based on his academic strengths and weaknesses. The child is rewarded for

correct academic responses and appropriate social behavior by being given free time in the "high strength" area of the classroom, equipped with arts and crafts materials, games, toys, books, a phonograph, and a tape recorder. Problem behavior—hitting, spitting, kicking, "talking out" or yelling and screaming at the teacher, and "out of seat" movement—is ignored by the teacher and other students when it is used as an attention-getting device. If such behavior becomes dangerous to persons or property, the student loses free time he has earned.

The school nurse visits the home of each child enrolled in the special classes and helps the parents establish a program similar to the one used in the school. Four training groups were organized for parents of children in regular classes during the first 2 years. Additional groups are planned for the current school year.

At the end of 2 years, 16 of the 29 students in the adjustment classrooms were able to return to regular classes. The teachers considered the social behavior of all students to be within acceptable limits at that time. No student was then taking medication for control of behavior problems, although about 80 percent of the students had been on medication when they entered the program.

In 1969–70 a resource teacher was hired to support teachers in regular classes in planning and managing behavior of disturbed students. She consulted with more than 70 teachers in 27 schools, and worked closely with 42 students who remained with their classes. Ten training sessions were held for 154 teachers and principals.

William L. Findley, supervisor of special education in Great Falls, is director of the project and Ray Beck, psychologist, is program coordinator.

Child health

In 1970 a teenager in the United States is infected with venereal disease almost every minute of every day, according to the Public Health Service's Center for Disease Control in Atlanta, Ga. The Center has estimated that about 1,300 new cases of infectious venereal disease—gonorrhea, primary syphilis, and secondary syphilis—occur each day in the 15–19 age group and about 1,900 new cases occur in the 20–24 age group.

For gonorrhea, the rates among teenagers and young adults during the 1960's showed a sharp upward trend. For example, from 1965 to 1968, gonorrhea increased from 401 reported cases per 100,000 persons to 611 reported cases per 100,000 persons in the 15–19 age group and from 918 reported cases per 100,000 persons to 1,251 reported cases per 100,000 persons in the 20–24 age group. Public health officials believe that reports are made on only one out of every four treated cases of venereal disease.

For the 1968 calendar year, 5,804 cases of gonorrhea were reported among children 14 years of age or younger. Of the 111,829 cases of venereal disease reported in the 15–19 age group that year, 97 percent were gonorrhea.

The incidence of syphilis in all age groups is now increasing, after a gradual decline from 1966 to 1969. Provisional data for fiscal 1970 indicate an 8.5 percent increase in reported cases of primary and secondary syphilis; a breakdown of figures by age groups is not yet available.

Syphilis caused 15 infant deaths in 1967, a decrease of 10 from the previous year, the center reports. In 1968 a total of 327 cases of congenital syphilis was reported in infants between birth and 1 year of age, compared to 277 cases in 1969.

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By mid-September, more than 13 million doses of rubella vaccine had been given to children in public programs and between 2 and 3 million doses had been given by private physicians, under the nationwide Stop Rubella campaign launched by the Public Health Service's Center for Disease Control in June 1969. About half of the vaccine used in the United States to date has come from the Federal government, with the remainder from State and local resources. State and local health departments are conducting the active immunization programs.

Clinical reactions from the rubella vaccine are less common than from the regular measles vaccine, according to CDC officials. However, some transient joint pain and swelling have been reported among vaccinated children. The small joints of the hands and knees are most often affected, with the condition beginning 2 to 8 weeks after vaccination and lasting 1 to 8 days.

Many voluntary organizations are working with local health departments in the Stop Rubella campaign under the leadership of the National Center for Voluntary Action, 1735 Eye Street N.W., Washington D.C. 20006. Among them are labor, religious, veteran's, women's, youth, health, and fraternal organizations; chambers of commerce; service clubs; and associations of parents and teachers. In addition to helping with record keeping and other clinic operations, the volunteers are working on publicity, organizational activities, and fund-raising.

Infant development

A pilot infant project that enlists parents in promoting optimal development of very young children through a program of observation and selective intervention was started during the fall at the Dubnoff School for Educational Therapy in North Hollywood, Calif. The program is focused on the emerging personality of infants at least 6 months old, some of whom appear to be developing normally and some of whom exhibit behavior difficulties without apparent organic cause, such as apathy, restlessness, hyperactivity, lack of response to stimuli, poor eating and sleeping habits—indicating they are at high risk of developing emotional problems as they grow older.

The theoretical concept for the project—that intervention will help prevent deviant behavior or correct it before it becomes stabilized—stems from the work of Emmi Pikler of the National Methodological Institute for Infant Care and Education in Budapest, Hungary. The project's design was tried out in a prepilot program involving six infants and their mothers, at the Dubnoff School's Infant Center between June and December 1969 under the guidance of Madge Gerber, project director.

The infants and mothers spent 2 mornings each week at the center in an environment designed to facilitate spontaneous exploration and learning. Mrs. Gerber demonstrated methods of selective intervention that allow the child to reveal himself, to make his own choices, and to evolve his own style of mastery. After learning the techniques of accurate observation, each mother watched her own child's behavior through a one-way mirror when he was

by himself, with other infants, and with other adults. All mothers participated in planned discussions with staff members and other mothers. The director visited each home from one to three times during the study period.

Extensive tests were performed before, during, and after the prepilot program. Followup studies of the infants in the prepilot program as well as in the pilot project will measure the long-range effects of changes on the quality of the infants' development, the mothers' attitudes, and the quality of interaction between the mother and infant.

Mental health

The Jewish Vocational Service of Chicago recently reported on a 3-year study of the progress of 76 emotionally disturbed adolescents in vocational rehabilitation programs integrated with the programs of child care agencies that were treating the adolescents and their families. Supported with a Federal grant from the Children's Bureau, the study was carried out from June 1964 to October 1967 under the direction of William Gellman, the agency's executive director.

While as a whole the adolescents did not show significant changes on measures of improvement, the data revealed the existence within the total group of two subgroups: a high performance group of young people who did profit from the program, and a low performance group of young people who declined in performance. The young people in the high performance group displayed better capacity for work before, during, and at the end of their vocational programs and seemed to have a capacity to recognize, take responsibility for, and learn from their own errors. In contrast, the young people in the low performance group seemed to be poorer workers in the beginning and to react to failure to perform to their own satisfaction with frustration, anger, and blame directed at the people about them.

The age of the participants on entering the program seemed to make no difference in their performance.

Because the young people involved in this study were emotionally disturbed, the staff was confronted with much moodiness, manipulation, and testing, according to Dr. Gellman. He found that the younger staff members seemed to bear up better under physical strain of the program, but that crises were handled best by staff members with professional training, regardless of age.

Indian youth

A reluctance of young Indians to enter the white man's world because of strong feelings of Indian identification was revealed in a demonstration project to explore the possibility of intercultural exchange between the students of an Indian boarding school and white families in the surrounding community, according to John D. Little, the project director. The project, called the Transitional Opportunities Project for Students (TOPS), was undertaken in August 1967 by the Lutheran Social Services of South Dakota, with support from the Children's Bureau, and was closed in June 1970 because of lack of participation.

The project's primary objective was to learn if young Indian students' process of accommodation to the dominant society would be aided by their association with white families.

In the beginning, 60 boys and girls from the sophomore class at the Bureau of Indian Affairs boarding school at Flandreau, S.Dak., were selected as an experimental group and 60 others as a control group. All had lived on reservations before coming to the school. Each TOPS student was to be invited by a host family for weekends and if possible to live with the family all or part of the summer. This was to give the student an opportunity to live and perhaps to work in an off-reservation community.

From its inception the project encountered many problems. Prejudice and fear among both Indian students and prospective host families hampered arrangements. Many of the students had severe social and emotional problems and so found it difficult to relate to any adult, particularly a white adult. Nearby communities were hostile toward Indians. Some host families were unrealistic in their expectations of the young people. Other obstacles were refusal of parents to grant permission for a young person to participate in the summer program; inability to find suitable host families; the scarcity of available jobs; and reluctance of students to carry through their plans.

Although 32 students had expressed interest in living with host families during the summer of 1968, only eight did so. However, largely through the efforts of a student coordinator, 24 students stayed with host families in the summer of 1969. Weekend visits during the school year were the most popular part of the project; 36 students participated in the 1968–69 school year.

Summer placements with local families were most successful for girls, for students who showed unusual motivation, and for students who had no acceptable alternative living arrangement, the project found. It also found that families that welcomed the students with warmth, but without pressure or intimacy, were the most successful.

Miscellaneous

An interim report for 1970, listing programs of group infant care, has been published recently by the Cyesis Programs Consortium, with support from the Children's Bureau. Persons with information about additional group infant care programs are asked to submit brief descriptions for the final report, to be published later. Copies of the interim report are available from the Cyesis Programs Consortium, Room 505, 1145 19th Street, N.W., Washington, D.C. 20036.

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Research Relating to Children, a publication issued periodically by the Clearinghouse for Research in Child Life, Children's Bureau, has been transferred to the ERIC Clearinghouse on Early Childhood Education at the University of Illinois. The publication contains abstracts of studies relating to children or their families in such areas as child growth and development, intelligence, personality, education, social adjustment, family life, mental retardation, and physical and emotional disorders as well as studies of service programs in the fields of child health, child welfare, and special education. Bulletin No. 1 covered research reported between December 1, 1948, and June 30, 1949; Bulletin No. 26—the final issue prepared by the Children's Bureau—covers research reported between January and May 1970. It will soon be off the press.

CHILDREN AND THE MASS MEDIA

The influence of television programs, comic strips, books, and other media of communication on children and ways to improve such products were considered during 2 days of hearings in Washington, D.C. in mid-September. The hearings, which comprised the second meeting of the Forum on Child Development and Mass Media of the White House Conference on Children, brought together about 100 people to listen to testimony from representatives of the mass media, child development specialists, and others who work with children or their materials.

The major questions considered were how to get the best "mix" between the ideas of the producers and creators of children's programs and literature and the knowledge of child development specialists; what artists and other creative persons need from the specialists; and what they would use.

The forum, one of 24 preparing material for the White House Conference on Children, is using the testimony from the hearings in compiling its report and recommendations for the Conference to be held in Washington Dec. 13–18. Fred Rogers, creator of the children's television program, "Mister Rogers' Neighborhood," is chairman of the 16-member forum; Morrie Turner, creator of the "We Pals" cartoon, is its vice chairman. Other members include representatives of various professional fields, the producers of educational materials for children, and concerned citizens.

Advice from the experts

A pediatrician, T. Berry Brazelton of Cambridge, Mass., maintained that after watching TV for an hour, the child is exhausted because he has been passively involved in life "out there" with its violent fantasies: "The child's ego structure is laid bare and he is forced to reorganize himself all over again." Dr. Brazelton praised the programs, "Mr. Rogers' Neighborhood" and "Sesame Street," for "demanding that the child be actively involved." He noted that the older a child gets, the easier it is for him to get "hooked" by TV, for he loses his power to "tune out" or "tune in" visual and auditory cues.

An optometrist, Bernard Mallinger of Pittsburgh, Pa., spoke of the importance of the perceptual development of the child in enabling him to sort out and deal with experiences intelligently. "From my point of view," said Dr. Mallinger, "the child is in school from day one of life. It is this school, his education by experience, that provides so much of the substructure of intellectual growth."

A psychoanalyst, Helen Ross of Washington, D.C., testified that some children find help in overcoming their difficulties from the warm positive attitudes in television programs. She added, however, that TV performers and scriptwriters ought to know something about children in different age periods, especially about their emotional growth.

Different viewpoints on the value of advice from child development experts were expressed by producers of programs and materials. One, Ezra Jack Keats, a writer of children's books, said he finds any rules and regulations inhibiting. Another, Carl Nater, president of the Walt Disney Educational Materials Co., said the film producer should accept what the experts say "if it is good." But then he posed a problem: Who determines who is an expert? And will today's expert be tomorrow's expert in a field so subject to "transitory techniques" and "widely varied opinions" as education?

Still another producer, Morton Schindel of Weston Woods Studios, maintained that the most valuable training in communicating with children is "to understand ourselves." What the field of communications for children needs, he said, are authors with "conceptual talent" and illustrators who have something to convey.

In regard to the content of children's TV programs, Chuck Jones, director of Children's Programs for the ABC network, advocated that each program have at least two of the following three components: (1) entertainment, (2) education, (3) stimulation. In the forthcoming TV show "Curiosity Shop," he said, children will be helped to perform feats that require more physical skill than just turning on the TV set.

One of the forum members, Joan Ganz Cooney, brought up the problem of how to reconcile differences in audiences. For parents of children from the lower socioeconomic groups who may need cognitive stimulation, the media might stress the importance of reading to children, she suggested, while for children from middle-class homes, who may be exposed to more "good conversation," the media should probably convey the message "relax and enjoy your children." Neil Hickey, New York bureau chief for *TV Guide*, suggested setting up a mechanism through which the TV stations could produce and exchange programs for children to reflect the rich variety in our country.

Evelyn Sarson, cofounder of Action for Children's Television, told of the organization's goal of having all commercials eliminated from children's programs and a "minimum of 14 hours of programs weekly" provided for children of different age groups.

Window to the world

An emphatic statement that TV could never be more than an auxiliary to the parent or the teacher in educating a child came from Bob Keeshan, Captain Kangaroo of the TV series, who could not be present at the hearing. The basic purpose of a good TV program for children, he said, is to serve the child as a window to the world around him. "It cannot teach the child to read, but only make him want to read."

Senator John Pastore, chairman of the Senate Subcommittee on Communications, and Dean Burch, chairman of the Federal Communications Commission, were the concluding speakers at the hearings. Both emphasized that the broadcaster is responsible for determining what goes over the air. Senator Pastore, however, pointed out that "parents, educators, producers, writers, social scientists, the FCC, and we in Congress can make our advice available" to the broadcasters.

At the conclusion of the hearing Chairman Rogers expressed the hope that a committee be established to continue looking at the problems, and that a permanent institute be set up to serve as a link between child development specialists and those in the mass media. Edward Zigler, director of the Office of Child Development, has offered the forum the services of OCD in following up on the latter suggestion.

Shirley Winston

IN THE JOURNALS

Questions about rubella

The New England Journal of Medicine for July 30, 1970, contains two articles and an editorial that raise some questions about the possibility of eradicating rubella—and so protecting the fetuses of pregnant women from being damaged by the virus—by inoculating children with an attenuated vaccine.

One article reports on an epidemic of rubella in four units of a children's institution 5 months after some of the children had been immunized with an attenuated virus vaccine. ("Clinical and Serologic Studies in an Outbreak of Rubella in a Vaccinated Population," by Te-Wen Chang, M.D., Suzanne Des-Rosiers, M.D., and Louis Weinstein, M.D.) It reports that while none of the vaccinated children showed clinical signs of the disease, serological tests showed that 50 percent of them had been infected with the wild virus, thus raising the question of whether vaccinated children might become unsuspected carriers.

The other article reports on a case of vaccine-strain rubella in a nonvaccinated child, which may have been contracted from a vaccinated member of her family. ("Controlled Family Study of Live, Attenuated Rubella-Virus Vaccine," by Lewis B. Lefkowitz, Jr., M.D., Robert R. Rafajko, Ph. D., Charles F. Federspiel, Ph. D., and Robert W. Quinn, M.D.) It raises the question of whether a pregnant woman could be infected by a vaccinated child and pass the infection on to the fetus.

In the editorial, John F. Enders, Ph. D., cites these and other research reports as suggesting that there are variations in the degree of immunity conferred by vaccination, that some vaccinated persons may become carriers of either the wild or attenuated strains of the virus, and that women vaccinated in childhood may eventually lose their immunity. While he suggests research on "more direct methods" of protecting unborn children, he advocates that doubts about the long-range effectiveness of the present nationwide rubella vaccination program "not for the present be allowed to interfere with its continuation."

Work potential in AFDC

Women receiving public assistance under the program of Aid to Families with Dependent Children (AFDC) who have a high school education or previous work experience and jobs skills have had to face just as many barriers to employment as those with less education and training, according to an analysis of data from employability studies reported in the July–August 1970 issue of *Welfare in Review*. ("How Employable are AFDC Women?" by Perry Levinson.)

Of the women studied, the author finds that 44.5 percent had a high employment potential in 1968 as defined on the basis of a high school education and past experience in skilled or white-collar jobs, a significant increase from the 25.3 percent in 1961. He points out that women in the program who were under 30 years of age and those who were living in urban areas were better educated and had better occupational skills than did the older women in the program and those living in rural areas.

According to the author, many conditions prevent women with high employment potential from applying for work. The barriers include children under 8 years of age (76.6 percent of the women with low employment potential and 81.7 percent of the women with high employment potential); poor availability of day care (51 percent, low potential, and 50.2 percent, high potential); poor general health (45.9 percent, low potential, and 37.6 percent, high potential); and low self-esteem (41.5 percent, low potential, and 33.2 percent, high potential). He reports that 37.5 percent of the high potential group and 29.5 percent of the low potential group had at least four barriers to employment.

As a byproduct of his study, the author finds that eligibility policies of cities and States in regard to AFDC act to exclude women with high employment potential.

Parental views on TV

Differences in both educational background and class—as defined by the father's occupation—make a difference in the way parents react to their children's use of television, the greatest difference being among fathers, according to two sociologists writing in the August 1970 issue of the quarterly, *Marriage and the Family*. ("Parental Perceptions of the Role of Television in Parent-Child Interaction," by Cora A. Martin, Ph. D., and Leonard Benson, Ph. D.) They are reporting on a study they made in 1966 of the television habits of 183 white families in Omaha, Nebr., who had children in the sixth grade. Individual interviews with the mothers and fathers were used to determine parental attitudes toward television habits, and the results were classified by social class (upper, middle, and "working") and the level of the parents' education.

The authors found that the attitudes and behavior of mothers toward television viewing by their children were similar across class and educational lines, although working-class mothers tended to make the strictest rules. Working-class fathers tended to be the most indifferent. Upper-class and professionally educated fathers discussed the content of television programs with their children more frequently than any other group, but the next most frequent group in using television as an educational aid for their children consisted of working-class mothers with less than a high school education.

Suburban state of mind

Richard Sennett, writing in the September 1970 issue of *Transaction*, presents an analysis of the consequences to family life of living in one-class communities where all inhabitants have approximately the same kinds of background, values, and income. ("The Brutality of Modern Families.") In his view, the outstanding characteristic of such family life is the intensity of family relations. This he describes as a "state of mind" in which family mem-

bers "believe that the actions and feelings that transpire in the family are in fact a microcosm of the whole range of 'meaningful' actions and feelings in the world at large."

This style of living tends to reduce all family members to equality, consequently limiting the possibilities for sophistication and tolerance of its members as individuals, the author maintains. He points out that in such families conflict is viewed as bad, and that individuals feel very anxious and guilty if conflict does occur—for example, when differences arise from the normal maturing of the children.

Children in one-class communities—such as the modern suburbs—are denied the growth experiences that come from contact with really different people and ideas, the author maintains. The "ultimate good" in such areas, he says, is regarded as recreation involving the whole family.

He suggests that such views of life produce "passivity". When people explain proudly what they gave up for the sake of the children, they are willing to sanction repression of the poor, the different, so that there "need be no intrusions on the 'meaningful' circle of one's own life, the intimate relationships between Pop, Mom, and the kids."

readers' exchange

GROB and VANDOREN: not for delinquents

I am somewhat concerned about an article that appeared in the May-June issue of CHILDREN entitled "Helping Houseparents Find and Use Their Creativity" by Harry E. Grob, Jr., and Eric E. VanDoren. My concern has been shared by several of our Board members.

Our concern is with the references to Chaddock Boys School as a private institution for juvenile delinquents. This is a misstatement of fact. I am sure that some of the parents of boys at Chaddock would be upset by such references.

Among the purposes of Chaddock Boys School as stated in our constitution are the following:

"To provide a Christian home, school and a wholesome environment for the care and education of boys where circumstances do not permit the boy remaining in his home and/or where the home is unsuitable for the boy's physical, mental, emotional, and spiritual growth and development.

"To provide a period of preparation or transition for boys to go into foster homes.

"To serve predelinquent emotionally disturbed and/or neglected boys who can better function in a group living environment than in a private home.

"To provide foster home placement for those boys who can best function in this type of environment."

Thus, Chaddock Boys School is a residential treatment-oriented agency serving predelinquent emotionally disturbed adolescent boys.

Charles W. Johnson
Executive Director
Chaddock Boys School
Quincy, Ill.

PEARSON: A lode to be mined

John W. Pearson deals with a most difficult problem: what provisions should be made for delinquents who juvenile courts decide need supervision and special care? ("A Differential Use of Group Homes for Delinquent Boys," CHILDREN, July–August 1970.) They might be put on parole, sent to a training school, or placed in a foster home. The article recognizes the limitations in each of these plans, and it describes an experiment with research in the use of group homes (actual homes of the foster parents). The results are not encouraging.

Significant dimensions of these situations are not included. I hope that they will be when the data are fully analyzed. As the experience with "Cottage Six" makes vivid, delinquent boys (and others) develop a potent subculture as they live together. This needs attention. A related factor is group composition. Apparently the grouping described in this article was largely based on a classification scheme, and boys in the same category were put together in a group home. For example, boys classified as "Type II . . . manipulator or cultural conformist" were in one home. If these six boys were all manipulators, it raises serious questions about using this category as a basis for grouping. Unfortunately the article does not relate the group home parents' and parole agents' ratings of changes in the boys to the categories.

The ratings, done at 2-month intervals, seemed to show poor results when the young people were in the homes for more than 4 months, especially in the eighth month ratings. Mr. Pearson indicates that the average stay for all of the 39 boys in the group homes was 5.4 months. Was there a selective process at work so that only the most difficult boys remained in the homes for 8 months? When some boys left, were others assigned to the homes? If so, did the "old timers" become leaders?

Arrangements with four of the seven sets of foster parents had to be terminated because they were not performing satisfactorily. Under these conditions, did the group home approach have a fair test? It would help to have separate tabulations of the ratings of those foster parents who continued through the full period and those who did not.

The ratings were based on behavior in the home and probably whatever was known about behavior elsewhere. There is still the question of how the boys act beyond the purview of the staff, and how they will behave in the future.

This experiment involves many variables and other complexities. I hope, however, that Mr. Pearson and his colleagues will mine all the gold that is there.

Saul Bernstein
Professor
School of Social Work
Boston University

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LEARNING TO TALK: speech, hearing, and language problems in the preschool child. HEW, PHS, National Institutes of Health, National Institute of Neurological Diseases and Stroke, Bethesda, Md. 20014. 1969. 48 pp. 45 cents.

Gives parents some guidelines to follow when they suspect that their child is troubled by one of the three communication disorders: speech, hearing, and language.

LEGAL BIBLIOGRAPHY FOR JUVENILE AND FAMILY COURTS: supplement 3, 1969. William H. Sheridan and Alice B. Freer. HEW, SRS, Office of Juvenile Delinquency and Youth Development. 1970. 36 pp. 45 cents.

This third annual supplement to a bibliography first issued in 1966 by the Children's Bureau lists selected references in 22 subject areas, among them adoption, child abuse, criminal law and procedures, custody, delinquency, domestic relations, due process for juveniles, family court and family law, illegitimacy, negligence, parental liability, probation services, and right to treatment.

A FEDERAL SOURCE BOOK: answers to the most frequently asked questions about drug abuse. Departments of Defense, HEW, Justice, and Labor and Office of Economic Opportunity. 1970. 32 pp. 25 cents.

Replies to questions about the abuse of such drugs as marijuana, hallucinogens, stimulants, sedatives, and other mind-affecting substances; and contains a glossary of users' terms.

ANNOTATED BIBLIOGRAPHY ON MATERNAL NUTRITION. Committee on Maternal Nutrition, Food and Nutrition Board, National Research Council and National Academy of Sciences. HEW, PHS, Health Services and Mental Health Administration, Maternal and Child Health Service. 1970. 199 pp. $1.50.

Includes selected materials published from 1958 through 1968 relating to research on maternal nutrition and the course of pregnancy.

KEY ISSUES IN INFANT MORTALITY—a report of a conference. Frank Falkner, M.D. HEW, PHS, National Institute of Child Health and Human Development. 1970. 84 pp. $1. Single copies free from Public Information Office, NICHD, Building 31, Room 2A–49, Bethesda, Md. 20014.

Reports on a meeting convened in April 1969 by NICHD to explore the medical and social aspects of infant mortality and discusses ways of decreasing deaths among infants in the United States and of assuring their intact survival.

BOYS IN FATHERLESS FAMILIES. Elizabeth Herzog and Cecelia E. Sudia. HEW, OCD, Children's Bureau. 1970. 120 pp. Single copies free from OCD.

Reviews and analyzes research concerned with the effects on boys of spending at least part of their childhood in homes without fathers and raises some questions about conclusions that relate the experience to juvenile delinquency, identity difficulties, and problems in intellectual and psychosocial functioning.

HEW refers to Department of Health, Education, and Welfare; OCD, to Office of Child Development; PHS, to Public Health Service; SRS, to Social and Rehabilitation Service.

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